State of Maryland / Department of Health and Mental Hygierie \bigcap 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Tinkler Harry Edward 17, 8:20 P DECEMBER 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 100 BROOKEBURY DRIVE REISTERSTOWN BALTIMORE CO If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month 7ay 1940)

Aug 1 7ay 1940 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 214-40-7746 65 Maryland **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or Items 23a or 28a-f eho the Medical Exprimer roust be notified at 1 Tyes 2 No Director Maryland **Baltimore** Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Brookebury Drive 21136 United States death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item eny Injury or other treumatic event, the Madical Experimen. page. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No White Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Automotive Dismantler Automotive Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Tinkler Emory Erma Meilke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue Tinkler, Wife 14218 Hanover Pike, Reisterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 12/27/2005 Baltimore, Maryland Timeral Se ice Licensee Brian T. Chisholm Funeral Services of Dulaney Valley, P.A. MOI113 Brian T. Chisholm Funeral. Services of Du 200 E. Padonia Road, Timonium, MD 21093

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, smooth, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ATMEROSCIEROTIC CARDIOVASCULAN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) ng physicien end es the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. use IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? Month Day Year 5 Other (specify) P.O. ☐Yes 2☐No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۾ PLRMUSIS 1 Yes 2 No Be Completed 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

Notyes 2 □ No page 2 autopsy performed? 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1X Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 NOther (Specify) SCENE 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 Yes 2 No within 24 hours after death.

To the Funerel Director: A completely filled in by the fi investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME DECEMBER 18, 2005 ess of person who completed cause of death (Item 23a) (Type Print) PENN STREET, BALTIMORE, MARYLAND, 21201 30. Name and age Upple NO 31. Date filed (Month, Day, Year) mgistrar's Signature State Registrar 0 2006 JAN 1 DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Reg. No. 005 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 25, 2005 1:05PM **Physician** Gladys B. Thomas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Clinton Southern Maryland Hospital Il Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State (Month, Day, Year)) 9. Birthplace (Month, Day, Year) 9. Birthplace (State (Month, Day, Year)) 9. Birthplace (Month, Day, Year) 9. Birthplace (Month 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 K F 60 Yrs. 219-46-6142 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 ehow amy injury or other treumatic event, the Mudical Exactle at market once. Brandywine MD Prince Georges 1X Yes 2 □ No Funeral Director 10f. Zip Code 20613 10g. Citizen of What Country? 10e Street and Number USA 17821 Horsehead Rd 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 X Never Married 2 ☐ Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gladys H. Harpe Joseph R. Thomas 2 19a. Informant's Name/Relationship (Type, Print)
Carolyn Thomas/Sister 19b. Mailing Address (Street and Number of Rural Route Number City of Town, State Zip Code) 17821 Horsehead Rd, Brandywine, MD 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State 1/10/06 Clinton, MD Resurrection 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Faneral Service Licen 22. Name and Address of Facility Adams Funeral Home-20605 Aguasco Rd. MD 20608 Aquasco, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Examiner HYPERTENSION PULMONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ate has been signed by the ettending physicien and page 2 should be detached for use es the burial-transit or Attending Physician: The law requires that the death certificate be executed PULMONARY HRONIC OBSTRUCTIVE Due to (or as a consequence ol) Division of Vital Records, P.O. Box 68760, FAILURE Be Completed by Physician/Medical NEY IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Tinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ABDOMINAL WALL 1 Tes 2 No 3 Probably 4 Unknown TPERTENSION 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? this certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: 1 N npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 2 Accident 5 Pending investigation atter death.

Director: Aft
d in by the fur 1 Tes 2 No 6 Could not be determined 3 🗌 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) tilled in by 4 Homicide within 24 hours a To the Funeral C 29e Cartillar List Contryling Physician: To the bast of my knowledge death control of the time date and place and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D48158 DEC 25, 2005 Juscon we and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6192 OXON HILL ROTED #500 OXON HILL OSIA, 5150M 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year FOTP Physician George Vaughn December 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Center NA 5. Social Security Number Maryland 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 12-21-54 Birthplace (State or Foreign Country) **Funeral** Days XXM 2□F Yrs Md. 217-66-5784 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1X Yes 2 □ No NA Baltimore Director Md. 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? or items 23a or USA 21218 1634 E. 32nd Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Never Married 2☐ Married 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black þ 3 Widowed 4 Divorced is 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. Item 27 is marked other than "natural; Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Custodian llth grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maddox Florence Vaughn William ္က 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1634 E. 32nd Street, Baltimore, Md. Mother Florence Carter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1-9-06 Mt. Zion Cem. Lansdowne, Md. Baltimore, Md. 22. Name and Address of Facility 21202 21. Signature of Funeral Service Licensee 1101 E. North Ave. March F.H. East la Wane 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 14 days Immediate Cause (Final Status Epilepticus **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner anding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physicien should be detached for use as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 Yes 2 A 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 X No certificate has 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check on vore Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No To the Hospital or Attency within 24 hours after death To the Funeral Director.. 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗍 Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P18816 December 31, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene Street Bactimore mo 21201 Bha 22 Iveca MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

9 2006

JAN 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per Dr., G851, OL/12/06dhb Reg. No. For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 7208 WILSOY relember 9 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Cente BUTIMOVE
If Under 1 Year If Under 24 Hrs. N/A 8. Date of Birth (Month Day, Year) April 1, 1924 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 🔀 M 2 🗆 F 215 14 6260 81 Maryland Director Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show r then "natural", or items 23s or 28s-f ehov the Maxical Examiner must be notified at Glen Burnie 1 ☐ Yes 2 No Anne Arundel Maryland Direct 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S. 21061 7975 S. Crain Highway Apt. 412 filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give 1945− Year or Dates: 1 Never Married 2 XMarned White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Military Police Army 12th Ith and Mental Hygie 27 Is marked other Ir traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Beeman Joseph Arthur Wilson Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If itsm 27 is eny injury or other trau Robert Wilson / Son 216 - 8th Avenue Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □Burial 2 □ Cremation 3 □ Removal from State Garden of Faith Cem. 12/14/2005 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. manuou Baltimore, Marvland 21225 4001 Ritchie Highway 23a. Part. Enter the disease, or or mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Septic Shock Physician /Medical Due to lor as a consequence of) Examiner Pheumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physicien and s the burial-transit Agonal Aspiration The law requires that the death certificate be executed aspiraction Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ Acute Renal Failure 3 Probably 4 Unknown 1 ☐ Yes Completed No 24b. Were autopsy findings available prior to completion of cause of death? Liver toxicuty 24a. Wasan autopsy performed (es 2) K No certificate 1 🗌 Yes of Vital 25. Was case referred to medical examiner?
1 Tyes 2 No Be 26. Place of Death Check only on Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 D patient 2 ER/Outpatient this 3□ DOA After thi 28a. Dat of Injury (Month, Day Year) 27. Manner of Death 1 X Natural 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Division 5 Pending M 1 ☐ Yes 2 ☐ No investigation Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funeral I certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Glenda Parker

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) JAN 1 2 2006

3

4940 Eastern Avenue

32. Registrar's Signature

Baltimore, Maryland 21224

		•	For State Registrar		State of M	laryland /		artment <i>tificate</i>			and M		giene Regino		435	05
7	Physici	an	1. Decedent's Name (First, Mi	ddle, Last)								2. Date of De Month	Da		3. Time o	of Death
3	/Media	al	Norman 4a. Facility Name (If not institu	tion also a	lmot and number	1	Your	1g 4b. City, T	Forum or I	Location	of Dogsh	12	30	2005 County of Dea	7:p	IVI
	Examir	er	250 S. Spr		Ct.	,				more	n Death		40	NA	un	
	Funeral		5. Social Security Number	6. Sex	7. Ag	ge (In yrs. last	birthday)	If Under 1		If Under	24 Hrs. Min.	8. Date of Bird (Month, Da	th V Year	9. Bi	rthplace (State ountry)	or Foreign
16	Director		219-26-7514	1/8	M 2 F	66	Yrs.	MOTUTS	Days	Hours	WIII.		3–39		Md.	
	and **		Usual Residence of Decedent 10a. State 10b. Cou	nty		10c. City, To	own or Lo	cation							10d. Inside C	City Limits
	Maryl f sho	ŗ	. bM	N/	4		В	altimo	ore						1 (X Yes	s 2 □ No
	r 28a	irec	10e. Street and Number					10f. Zip (10g. Cit	izen of What C	ountry?	
	Ih wit	ai D	250 S. Spring	ct.				2	1231					USA		
	tems	Funeral Director	11. Marital Status		Was Decedent Armed Forces?	?	13.	Was Decede f Yes, speci	ent of His rfy Cuban	spanic Orig n, Mexican	gin? (Spec i, Puerto P	cify Yes or No Rican, etc.)	-	14. Race - Am Black, Wh		_
36	rs afte	by F	1 ☐ Never Married 2 ☐ N 3 ☐ Widowed 4 ②		1 ☐ Yes 2X If Yes, Give Year or Dates:			1 ☐ Yes 2	No No	Specify:				Specify:	Black	
21215-0036	72 hours after death with the Maryland natural; or items 23s or 28s-f show Ecal Extrainer must be mailfied at	ted	15. Deced	lent's Educ	ation		6a. Dece	lent's Usual	Occupat	tion			16b. K	ind of Busines		
215	within 7 ene. than "n te Med	Completed	(Specify only hig Elementary/Secondary (0-1)		College (1-4or	5+)	life.	kind of work OO NOT use	k done di e retired)	uring mosi	of workin	g				
21	ygien ygien f, III	Con	8th grade				Sel	f Emp						hoe Rep	airman	
Maryland	12 should be filed within "h and Mental Hygiene. 7 is marked other than "traumatic event, the Mac	Be	17. Father's Name (First, Midd	le, Last)		γ	oung				rs Name Airle	(First, Middle, an	Maiden	_{Sumame)} Hayr	es	
<u>Z</u>	thould od Me mark matic	2	19a. Informant's Name/Relation	nship (Tvp	e. Print)	_		a Address	(Street as				er. City o	or Town, State,		
	nd 2 s lith ar 27 is r trau		Harriett Wil		,					- 305				ore, Mo		31
re,	of Hear		20a. Method of Disposition			come	of Dispo	sition (Nam-	e of		-	ate		ocation - City o		
altimore,	Page nent c		1 ☑Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		moval from State			ilĺ Ce		1	1-6-	06	An	ne Arur	del Co	., Md.
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturati, or items 23a or 28a-1 show any injury or other traumatic event, Ite M. dical Examiter must be multilised at Once.		21. Signature of Funeral Serv	ce License	wa	ne	22	. Name and March						ore, Md . North		2
	25 X.		23a. Part1. Enter the disease shock, or heart failure.	or complication	ations that cause	d the death. D	o not ent								Approxima Interval Be	tween
	Physician		Immediate Cause (Final disease or condition		Cholai	naioc	acin	oma							Onset and	
	/Medical Examiner	a)	resulting in death)			s a consequenc		10								
y@ ∀)		er	Sequentially list conditions,	b.	Due to for an	в в вопрачиел	se off:									
-	uted J ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	*	,		,-									
o,	an and rial-tra	Еха	resulting in death) Last	C.	Due to (or as	s a consequent	ce of):									
8760,	cate be executed physician and the burial-transit	dicai		d.			_									
9	ertifica ling pt e as t	Med	IF FEMALE:			(- 1			
Вох	death certifi e attending d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23	ic. If yes, outcome 1☐Live birth 4☐Pregnant a	2 Fetal dea	ath 3[Ectopic pre						23d. Date of de Month		Year
P.O.	the de	iysic	1 □ Yes 2 □ No 9 □ Unknown		9□ Unknown	it time or death	5) Other (spe	cuy)							
	equires that the death certificaten signed by the attending fould be detached for use as	y Pt	Part II. Other significant cond	litions conf	ributing to death t	but not resultin	g in the u	nderlying ca	iuse givei	n in Part I.		23e. Did to	obacco i	use contribute	o the cause of	death?
of Vital Records,	w require been sig should b	Completed by	Chronic Ve	nal	failu	re						10	Yes 2	⊇ No 3 □ F	robably 4]Unknown
ecc	aw Isbu	plet			1							24a. Was		24b. Were a	utopsy findings completion of	available
= H	ate pag	Con										perfo	rmed?	death?	s 2 No	
Vita	Physician: Th this certificate al director, pag	Be	25. Was case referred to med examiner?	_	ospital:							(Check only o				
of	Phys rthis raldii	-: To	1 Yes 2 No 27. Manner of Death	110	28a. Date of Inju		Outpatier b. Time of		Bc. Injury		rsing Hor	ne 5 Residente 18d. Describe 1	dence	6 □Other (Sp	ecify)	
O	te the	ition	1 Natural 5 ☐ Per	ding	(Month, Da	ay Year)	Injury	M	Work'	?` 'es 2 ☐ l		04. 50301150 1	1014 11111	iy oddunod		
Division	Atter or dea ector by the	iffice	3 ☐ Suicide 6 ☐ Cou	ild not be	28e. Place of In	njury - At home	, farm, str	eet, factory,	office	-	2	8f. Location (S City or Tox		d Number or F	lural Route Nur	mber,
Ö	tai or rs afte al Dir ed in	Certification:	4 E Normelas		building, e	nc. (Specify)						City of Tov	vii, State	7)		
	To the Hospital or Attendi within 24 hours after dealh. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 Certification (Check only one)	ying Phys al Examin	cian: To the best er: On the basis of and manner st	of examination	dge, death and/or in	occurred a restigation,	it the time in my opi	e, date and inion, deal	d place, a th occurre	nd due to the d at the time,	cause(s date and) and manner a d place, and du	s stated. e to the cause((s)
	Withi To the comp	M	29b. Signature and title of cert			P. I.			License					te signed (Mon		
	0		My	Lyl	~~	PHYSIC	MAI		DS	5359	0		UA	JUARY	4,2	0060
2	U		30. Name and a id ss of pers	on who cor	npleted cause of	death (Item 23	a) (Type,	Print) (240	N	813	DOWA.	~(~ /		
	Sta	te	31. Date filed (Month, Day Ye	ar)	32. Red st	rar's Signature		A	*	MIT	1201	رو یا		2120	>	
	Regist		JAN	0 9 2	006 32. Redist	EN A	K A	Joseph .	1							

			1 - For Amend Items 2. Registrar 1. Decedent's Name (First, Middle, Last)	State of Maryla 4a,25,26,29a	per Depa Ce	rtificate of I	-	Reg-No	005 4	3 5 0 6
	Physici		Harold J. Yates					Month Mber	19 285	11:25PM
	/Medio		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death	40	County of Death	
			Doctor's Communit			Lanham			Prince Ge	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	i. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	Date of Birth Month, Day, Year V 27, 195	9. Birthpl Count	ace (State or Foreign try) unk
#	Director		Usual Residence of Decedent	77			140	V 27, 19.		
	show	_	10a. State 10b. County		City, Town or Lo				10	0d. Inside City Limits 1 ☐ Yes 2√ No
	28a-f	ectc	MD Prince G	eorge's	Landove	r Hills		100 0	tizen of What Coun	
	with t	급	3817 64th Avenue	/ 2			20784	Tog. Ci	USA	ury ?
	Jeath	era		12. Was Decedent Ever in	U.S. 13.	1	ispanic Origin? (Specify n, Mexican, Puerto Rica	Yes or No-	14. Race - America	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic svent, the Medical Examinat must be notified at	by Funeral Director	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify Cubal 1 ☐ Yes 2 🌠 No	n, Mexican, Puerto Rica Specify:	n, etc.)	Black, White, & Specify: bla	
5-0	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation a completed)	16a. Dece	dent's Usual Occupa	ation during most of working	unk 16b. K	(ind of Business/Ind	lustry unk
121	ne.	ld m	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)			
	filed within Hygiene. other than ent, the Me		unk unk 17. Father's Name (First, Middle, Last)	nk		unk	18. Mother's Name (Fir	st. Middle. Maider	n Sumame)	unk
Maryland	2 should be i and Mental I is marked of sumatic svs	To Be	, , , , and a status (state and a state an					0.,	, , , , , , , , , , , , , , , , , , , ,	
ary	2 shou and M is mar	-	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Maili	ng Address (Street a	and Number or Rural Ro	ute Number, City	or Town, State, Zip	Code)
	1 and 2 Health Iam 27 i		Doctor's Community		The second secon		Road Lanha		20706	
Baltimore,	00		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	cemetery, crei	osition (Name of matory or other place	Date	20c. L	ocation - City or To	wn, State
Balt	permit. Pag Department Important: I sny injury o		21. Sign ture Funeral Service License Ronal S. W		r St	2. Name and Addres tate Anato altimore,	os of Facility Omy Board 6: MD 21201	55 W. Bal	ltimore S	treet
'n			23a. Parti. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the de- le cause on each line.	ath. Do not en	ter the mode of dying	g, such as cardiac or res	spiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Heguira	d in	munode	ficrency	Synd	Wme	Onset and Death
	/Medical Examiner		Tosailing in addition	Due to (or as a conse	equence of):		O	•		
-%	30 S F	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):					
	icuted nd transit	Examiner	that initiated events	Deli	eiur	က် <u></u>				
8760,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a conse	equence of):				1	
687	physi s the t	dle	d	= =====================================						
Box (ath certific attending p for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of preg		75			23d. Date of delive	ry
	ne death the atte	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)			Month	Day Year
P.0	that the di ed by the detached	Phy	9 ☐ Unknown Part II, Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause give	an in Part I	23a Did tobacco	use contribute to the	e cause of death?
Records,	9 G	d by	Taltin, and organization of		Joannia III III G	moonlying outdoor give	STERRED CALLET	1 ☐ Yes 2		ably 4 □Unknown
000	aw requir s been si 2 should	Completed						24a. Was an	24b. Were autop	sy findings available
		E O						autopsy performed? 1 ☐ Yes 2 🛣 No	death?	npletion of cause of 2□ No
Vital	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?				26. Place of Death Ch	neck only one)		
of \	this at di	ုင	1 ☐ Yes 2 📉 No		ER/Outpatier		4 Nuising Home)
	ding After fune	tlon:	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work	/ at 28d. ⟨? Yes 2 □ No	Describe how inju	iry occurred	
Division	Attending r death. sctor: After by the funer	ifica	3 Suicide 6 Could not be	28e. Place of Injury - At	home, farm, st				nd Number or Rural	Route Number,
Ö	ital or irs afte rel Dire	Certification:	4 Homicide determined	building, etc. (Spec	city)			City or Town, State	θ)	
	To the Hospital or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Physical Certifier Physical Certifi	ner: On the best of my kiner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the time vestigation, in my op	ne, date and place, and pinion, death occurred a	due to the cause(s t the time, date an	s) and manner as sta d place, and due to	ated, the cause(s)
	With To t	Σ	29b. Signaryte and trile of certifier	119		29c. License	number	29d. Da	ate signed (Month, L	Day, Year)
•			The auf 1	YN		200	158446	1 7	42120	05
			20. Name and address of person who co	mpleted cause of death (It	ет 23a) (Туре,	Print) 4/10/	058446 2000 LUCK	Polar	10-14	a anh Door
(4)	St	ate	31. Date judy (Mohih, Day) Yearn	32. Registrar's Sig	nature	01/8 0	DOD LUCK	m10	WAN UN	1000000
	Regist		- 1 5000 J	Mary St.	Walled !					

PIOPPO

29d. Date signed (Month, Day, Year)

SALIB-M MY

12.27.00

21804

Examiner Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, be detached ģ page 2 should has completely filled in by the funeral director, Certification: To After or Attending death. Director: within 24 hours after To the Funeral Dire Hospital

Physician

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event. The Modical Examinar must be notified at

al Hygiene. filed within

is marked of 2 should be

of Health of Item 27 i

Physician

/Medical

ö permit. Page Department of Important: If any injury or once.

Pages 1 ö

72 hours after

Maryland 21215-0036

Baltimore,

/Medical

29b. Signature and title of certifie 29c. License number of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addr MILLARD 106 MOMONS 32 Pagistrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

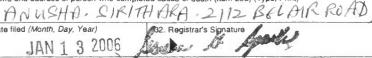
State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Cofield 2005 MARGARET /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death **Examiner** Upper Cheshpeake Medical Center HARTFORD COUNTY Bel Air Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year)
OCT 15, 1947 Birthplace (State or Foreign Country) al Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Bertie Co. NC 1 ■ M 2 🔀 F Yrs. 244-74-8192 58 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "naturel", or Items 23s or 28s-f ehow the Medical Examiner must be notified at 1 SYes 2 □ No HArtford Directo Edgcwood Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 625 HAVEN 21040 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if item 27 te marked other then Elementary/Secondary (0-12) College (1-4or 5+) Medical Rocords Socretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cofield Johnny Tiny LASSITER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Haven Place Edgewood, Nd. 21040 TROY WEAVER
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Aulander Cometery Dec 18, 2000 Aulander, NC 27805 4 □ Donation 5 □ Other (Specify) of Funeral Service Lice Sonatur 22. Name and Address of Facility P.O. 1304 185 Stephen M. Jenkins M0031KASSey Funeral Home At 23a. Part 1. Enter the disease, or complications that caused the disease, or heart failure. List only one cause on each line. Aulander, NC 27805 Approximate Interval Between Onset and Death GNSIVG Immediate Cause (Final disease or condition resulting in death) SMALL COLL LUNG CANCER **Physician** /Medical Due to (or as a consequence of): **Examiner** COMPRESSION DUE TO TUMOR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): as the burial-transit GUBRE Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Month 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? res 28 No 1 🗌 Yes 25. Was case reterred to medicat 26. Place of Death (Check only one) examiner? 25No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? Mannerol Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Hospitel or Attending Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, tarm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 200.

State Registrar 31. Date filed (Month, Day, Year) 3 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



		1 = For State Registrar	State of Marylan				ealth and Death	Mental Hy	giene Reg: No.	5 43509
Physicia	_	1. Decedent's Name (First, Middle, Last) Carole Ann	Apperson					2. Date of De Decem	ber ^{Day} 23	3. Time of Death 8:51 pm
/Medic Examine		4a. Facility Name (If not institution, give s Civista Medica)				Town, or Pla	Location of De	ath	4c. Count	
Funeral Director		5. Social Security Number 6. Sex 215 52 8895 1□	7. Age (In yrs. 57	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 H Hours Mi		**************************************	9. Birthplace (State or Foreign
e Maryland sa-f show lifted at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince		y, Town or Loc elten						10d. Inside City Limits 1X Yes 2 □ No
with th	I Dire	10e. Street and Number 10001 Behun Dr	ive		10f. Zip	Code 062	3			What Country? States
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event. Ite Medical Examinar must be notified at once.	d by Funeral Director		2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	l II	Vas Decec Yes, spec	offy Cuba	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	Special Special	ce - American Indian, lck, White, etc.
led within 72 h ygiene. her than "natu it, it e Medica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		life. L	kind of woi OO NOT us	rk doné d se retired	during most of w specto	r	P. G.	County
id be fil lental H ked oth ic even	To Be	17. Father's Name (First, Middle, Last) Harold Lawson					Leola	G. Al		me)
d 2 shou th and M t7 is mar traumat		19a. Informant's Name/Relationship (Type Sandra Linder	oe, Print) (daughter)	19b. Mailin	g Address 1 Be	(Street a	nd Number or Drive	Rural Route Numb Chelte	er, City or Town	y Land 20623
Pages 1 an ment of Heal ant: If item 2 ury or othar	3	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Real and Burial 5 □ Other (Specify)	1 - 1	Place of Dispos	it i y y i r o	ther plac	į			nd, Md.
permit. Depart import any inj		21. Signature of Euneral Service License	olden	4	. Name an 111	d Addres	nsylva	edar Hi nia Ave	ll Fun Suit	eral Home land, Md.
Physician /Medical		23a. Party Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the deat e cause on each line. Cardiores Due to (or as a consequence)	pirate				iac or respiratory a	irrest,	Approximate Interval Between Onset and Death
certificate be executed and right physicien and insert as the burial-transit and insert	dical Examiner	Sa uentially list conditions if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	End-Stage Due to (or as a consequence to (or as a consequence)	Rena	l Di	sea	se			5 years
death certifi e attending od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	death 3	Ectopic pr Other (sp					ate of delivery onth Day Year
requires that the een signed by th hould be detache	þ	Part II. Other significant conditions con	tnbuting to death but not res	ulting in the ur	nderlying c	ause give	en in Part I.			itribute to the cause of death?
a 8 C	e Completed	25. We are placed to redict						1 Yes	psy ormed? 2 No	Were autopsy findings available prior to completion of cause of death? 1 Yes No
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete he completely filled in by the funeral director, page	To B	25. Was case referred to medical examiner? 1 Yes 2 No 1 Namer of Death 1 Natural 5 Pending investigation	t 3 DC	8c. Injun Wor	er: 4 ☐ Nursing	Death (Check only G Home 5 Res 28d. Describe				
To the Mospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	2 Accident Suicide Suicide 6 Could not be determined 4 Homicide Homicide 4 Homicide Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Ru								
e Hospit 24 hours e Funera letely fille	edical	23a Cartifying Physical (Check only one)	ician: To the best of ry knower: On the basis of examina and manner stated.	wiedge, dear ition and/or inv	obcuttud restigation	at the tin , in my o	e, date and pla pinion, death or	ice, and due to the courred at the time,	cause(s) and in date and place,	and due to the cause(s)
To th To th comp	Me	29b. Signature and title of certifier Muhamil	2 Last 1/1	W	1		9 number 3483		-	ed (Month, Day, Year) Der 23 2005
6	91	30. Name and address of person who co Cook, Richard	E., Md.	12		old	Line	Center	Waldor	f,Md.20602
Sta Registr		31. Date filed (Month, Day, Year) DEC 3 0 2005	2. Registrar's Signa	ature	E					

State of Maryland / Department of Health and Mental Hygiene 005 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Samuel Lloyd Abbot Дм December 11:47 23, 2005 /Medical 4c. County of Oeath 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 611 Vanessa Court Finksburg Carroll If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours MM 2□F Yrs. 31 Dec. 4, 1974 Director 214-15-0522 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or itame 23a or 28a-f show other traumatic event, the Medical Examiner Gust be notified at 1 ☐ Yes 2 ☐ No Carroll Director Maryland Finksburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 611 Vanessa Court 21048 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: ል 3 ☐ Widowed 4 ☐ Divorced natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nit. Pages 1 and 2 should be filed within ertment of Heelth and Mental Hygiene. ortant: if Item 27 ie marked other then 'in]ury or other traumatic event, Ite Ma. Elementary/Secondary (0-12) College (1-4or 5+) Moving Company 11 Management 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Lloyd Abbot, III Cynthia Cotta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marsha Abbot/wife 611 Vanessa Court Finksburg, Maryland 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2√☐Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Depertment of important: if eny injury or once. Baltimore Crematory 12/28/2005 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) inflicted GSW to head **Physician** seconds /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and ched for use as the burial-transit The law requires that the deeth certificate be executed Oue to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No should be detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 200 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? res 2 2 No certificete 1☐ Yes or Attending Physician: 25. Was case referred to medical examiner?

Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home မှ 5 Residence 6 □Other (Specify) within 24 hours efter death.

To the Funerel Director: After thi
completely filled in by the funeral. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: for 1137A 5 Pending investigation 1 Natural 1 ☐ Yes 2 No Self-inflicted 65w to Head 2-23-05 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Vanessact. Tinksburg; MD To the Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number DO051924 December 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MN 2973 Manchester Rd Manchester State

DHMH 17 Rev 1/2001

Registrar

3. Time of Death

Reg. No.

2. Date of Death

	1. Decedent's Name	(First, Middle, Last)								Date of De Month	ath Day	ν.	ear	Time of	Death
Physician /Medical	ANN	1	BENJAMI	N								005	6:00	J A ^M	
Examiner	4a. Facility Name (If	f not institution, give s	treet and numb	oer)		4b. City, Town, or Location of Death					4c. C	4c. County of Death			
	но	LY CROSS I	HOSPTTA	т.			SILVE	R SPI	RING		M	ONTG	OMERY	Z	
Funeral	5. Social Security N	umber 6. Sex	7.	Age (In yrs.	last birthday)	If Unde	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Day MARCH	th v. Year)	9	. Birthplac	e (State o	r Foreign
Director	167-20-3		M 2 XF	83	Yrs.				P	MARCH :	29 19	22	SOUTÍ	I CAR	COLINA
D >	Usual Residence of 10a. State	10b. County		10c Cib	y, Town or Lo	nation							104	. Inside Ci	ity Limite
erylan ehow			non ant a										100		2 □ No
88-1-	MD	PRINCE G	FORGE S	MI	. RAIN										
or 2	10e. Street and Nun		_				ip Code					en of Wha		?	
first death with the Maryland in the maryland in thems 23s or 28s-1 show niner must be notified at Funeral Director	3155 QUE	ENS CHAPEL					20712					.S.A.			
r de	11. Marital Status		Was Decede Armed Force	es?	.S. 13.	Was Dec If Yes, sp	edent of H ecify Cuba	ispanic Or ın, Mexicai	rigin? (Spec n, Puerto F	ofy Yes or No Rican, etc.))-	 Race - Black, 	American White, etc		
036 urs afte ar, or i	1 Never Marri	ed 2 Married	1 ☐ Yes 2 If Yes, Give	K No		1 ☐ Yes	2 X No	Specify:	:			Specify:	BLA	CK	
1215-0036 within 72 hours after and then "natural", or ite a Medical Examina modeled by Fu	3 Widowed		Year or Date	es:	162 Dags	daawa I la	ual Osaus	ation			1 Ch Kin	d of Busin	(
15. 22 Language	(Spec	15. Decedent's Educ ify only highest grade	completed)		16a. Dece	kind of w	rork done d use retired	during mos	st of workin	g	IOD. KIN	d of Busin	1ess/maus	жу	
21215-00 ed within 72 hou ygiene. ner then "neture it, the Medical E. Completed	Elementary/Secon	ndary (0-12)	College (1-4	lor 5+)		[ETI		•/			PR	IVATI	E		
ind 2 be filed tal Hygin d other event,	17. Father's Name ((First, Middle, Last)				LUITY	71711	18. Moth	er's Name	(First, Middle					
and the fit		BUSBY						ROS				·			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If liem 27 is marked other than "natural", or items 23s or 28s-1 ehov eny injury or other traumatic event, the Medical Examinat must be notified at once. To Be Completed by Funeral Director		ame/Relationship (Typ	ne Print)		19b Mailir	ng Addre	ss (Street :			Route Numb	er City or	Town Sta	ate Zin Co	nde)	
Ma d 2 s th ar th ar trau	1	MIN/HUSBA			4	1000				101 MT					20712
Head Head	20a. Method of Disp		ND	20b. P	lace of Dispo	sition (N	ame of			ate		ation - Cit			20/12
ages int of ror or		☐ Cremation 3 ☐ Re 5 ☐ Other (Specify)	emoval from St	ate I	emetery, crei	-		'	12/30	/2005	WASE	HINGT	'ON . De	C	
Baltimore, permit. Pages 1 ar Department of Heam propriant: if learn only injury or other page.		neral Service License	. 11	, RO						B. JEN					
Ball permit Depart Import eny in	1	1	a 10							LANDOV				20785	
	23a. Part1. Enter th	ne disease, or complic rt allure. List only on	cations that cau	used the death									A	pproximat	le
	shock, or hea Immediate Cause (3 , -						iterval Bet Inset and I	
Physician /Medical	disease or condition resulting in death)	n a		LAC ARI									_		
Examiner				r as a conseq	derice or):										
	Sequentially list con	nditions, b	PNEUN Due to (or	1UNLA	uunee ot):			_				-			
executed executed en and rial-transit	cause. Enter Unde Cause (Disease or	orlying injury	DECDI	ERATORY	7 ADDE	er.									
y xecu	that initiated events resulting in death) t	i c		as a conseq		J1									
68760, ilficate be ex g physicien as the burial ledical Ex															
587 ficate phy s the															
Box 68760, eath certificate be executed attending physicien and for use as the burial-transit	IF FEMALE: 23b. Was decedent	t pregnant 2:	3c. If yes, outco			_					23	3d. Date o	of delivery		
	in the past 12 1 Tes 2	months?		th 2□Feta ntattime of d		⊒Ectopic] Other (:	pregnancy s <i>pecify)</i>	'				Month	Da Da	ay '	Year
	9 ☐ Unknown	2140	9□ Unknow	/n											
	Part II. Other signif	icant conditions con	tributing to dea	th but not res	ulting in the u	nderlying	cause give	en in Part I	I.	23e. Did	obacco us	se contribu	ute to the	cause of d	leath?
spring of big by bid be	<u> </u>									10	Yes 2□]No 3	Probab	ly 4 🔀	Jnknown
al Record The law require cete has been si page 2 should 1										24a. Was	an	24b. We	re autops	y findings letion of c	available
I Rec											rmed?	dea	ith?	_	ause of
Vital Fidelian: The certificate rector, pag	25. Was case refer	red to medical						26 Place	e of Death	(Check only	2K No	1	Yes 2		
Division of Vital Records, or attending Physician: The law requires lafter death. Director: After this certificate has been sign. In by the funeral director, page 2 should be entification: To Be Completed by	examiner?	10	ospital:	patient 2	ER/Outpatier	nt 3 🗆 🗆	Oth			ne 5 ☐ Resi		Other	(Specify)		
Physical Control	27. Manner of Deat		28a. Date of (Month,		28b. Time o		28c. Injun Wor	7		8d. Describe					
Division C or Attending P after deeth. Director: After t in by the funera	1 ZNatural 2 ☐ Accident	5 ☐ Pending investigation	(Month,	Day Year)	Injury	М		k? Yes 2. □]No						
ViSi Atten r deel ector by the	3 Suicide	6 ☐ Could not be determined	28e. Place o	f Injury - At ho	ome, farm, sti	eet, facto	ory, office		2	8f. Location (Street and	Number	or Rural R	loute Num	iber,
DIVI I or Att after d Direct I in by	4 🗌 Homicide	30,011111100	building	g, etc. (Specif	y)					City or To	wn, State)				

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2₹ No 1 Yes 2K No 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

27, 2005

DECEMBER

To the Hospital or Attending within 24 hours after deeth.
To the Funeral Director: Afte completely filled in by the fun

State Registrar

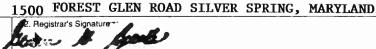
Certification:

> NOOSHIN FARR M.D. 31. Date filed (Month, Day, Year)

DEC 3 0 2005

29b. Signature and title of certifier

29a, Certifier



29c. License number D32247

			For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H			giene 1005	43512	
	Physicia	an	1. Decedent's Name (First, Middle, Last)	Alfred	Bernste	in		2. Date of Dea Month Decembe	Day Year		
	/Medic Examin		4a. Facility Name (If not institution, give st 9804 Justina Cour			4b. City, Town, or	Location of Deabrook		4c. County of De		
	Funeral Director		220-70-5875	M 2□ F 7. Ag	e (In yrs. last birthday) 49 Yrs.	If Under 1 Year Months Days	If Under 24 Hours N	frs. 8. Date of Birth lin. (Month, Day Sept 24	9. B 1956 Wa	irthplace (State or Foreign Country) IShington DC	
	ne Maryland 8a-f ahow Alfied at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Prince G	eorge's	10c. City, Town or Lo	Se	abrook		10g. Citizen of What 0	10d. Inside City Limits 1 No 2 No	
	3a or 2	P D	10e. Street and Number 9804 Justina Cour	t		10f. Zip Code	0706		USA	•	
920	be filed within 72 hours after death with the Maryland ital Hygiene. Indicate them "natural", or Itema 23a or 28a-1 ahow event, its Medical Examinar must be mutilied at	by Funeral Director	11. Marital Status 1 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No I	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? in, Mexican, Pu Specify:	(Specify Yes or No- lerto Rican, etc.)	Specify:		
Maryland 21215-0036	within 72 ho lene, 'than "natur 'the Medical.	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of d)	working	16b. Kind of Busines		
121	filed wi Hygien other th	e Cor	12th 17. Father's Name (First, Middle, Last)			Cler		Name (First, Middle,		nment	
/lan	S should be filed within and Mental Hyglene. is marked other then aumatic event, the M	To Be	Bernard Bernstei	n			H	elen Longo	0		
Man	d 2 should th and Men ?7 ia marka traumatic		19a. Informant's Name/Relationship (Type David Bernstein	e, Print) (Brothe)					r, City or Town, State, , MD 20706		
	Pages 1 and nent of Health out: If item 27 iry or othar tire.		20a. Method of Disposition 1 ☑ Surial 2 ☐ Cremation 3 ☐ Re		20b. Place of Dispo cemetery, cre	osition (Name of matory or other plac	ce)	Date	20c. Location - City of	or Town, State	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marka any injury or other traumatic <u>90068</u> .		21. Signature of Juneral Service License	Lemor			ss of Facility ${f R}$	endon/Hal	Adelphi, e Funeral ham, MD 20	Home	
Physician / Medical Examiner 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arressions, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death			
ς 68760,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	ical	resulting in death) Last		a consequence of):						
.O. Box	res that the death certific, signed by the attending pl i be detached for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	⊒Ectopic pregnancy ⊒ Other (s <i>pecify)</i>	<i>'</i>		23d. Date of d Month	elivery Day Year	
rds, P.	w requires that been signed I should be det	ρ	Part II. Other significant conditions con	tributing to death t	-	underlying cause giv	en in Part I.	23e. Did to		to the cause of death? Probably 4 □Unknown	
Il Records,	The law re ate has be page 2 sho	Completed						24a. Was autop perfor	rmed?// prior to	autopsy findings available o completion of cause of ? es 2 \sum No	
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpati	ent 2 □ ER/Outoatie	nt 3□ DOA Oth		Death (Check only o	<i>ne)</i> lence 6 ⊡Other (S _l	nacify)	
Division of Vital	er fe	tlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju		of 28c. Injur Wor	1000		now injury occurred	outy)	
Divisi	To the Hospital or Attendi within 24 hours after death. To the Funaral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of In building, e	jury - At home, farm, sl tc. <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Ton	Street and Number or vn, State)	Rural Route Number,	
	ve Hospita 24 hours ve Funara	edical (29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best ner: On the basis of and manner s	of my knowledge, dea of examination and/or it tated.	th occurred at the time timestigation, in my control	me, date and p opinion, death o	lace, and due to the occurred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)	
	To the within To the comp	M	29b. Signature and title of certifier		- Chap	29c. Licens			29d. Date signed (<i>Mo</i>	**	
	(10)		30. Name and address of person who co	mple House	death (Item 23a) (Type		9550 - bes 6				
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) DEC 3 0 2005	3 Regist	rar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygione Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Van **Physician** December Kitty Burdette 27,2005 3:12A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Southern Maryland Hospital Clinton Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Say **Funeral** Months 1 M 2 F 59 215-44-5763 <u>February 17.1946</u> Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10h County 28e-1 show r than "natural", or items 23a or 28e-f shov the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD Charles Indian Head 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 3450 Laurel Drive 20640 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mentai Hygiene. int: If Item 27 Is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify. White þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Safety Specialist Federal Govt or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Philip Taliaferro Cora Hampton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William Burdette/Husband 3450 Laurel Dr. Indian Head.MD 20640 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or otice. Brinsfield-Echols 12/29/05 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) M00945 21. Signature of Funeral Service Licensee AREHART-ECHOLS FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Tilin Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Palmonanduese **Physician** Manic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physicien and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as the been signed by the attending should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No s certificate has b lirector, page 2 s 1 Yes 2 (X) No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Propatient 2 ER/Outpatient 3 DOA Other: 1 Yes 2 No ို 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) eral Director: After th filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification; Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2/ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours after To the Funeral Dire 29a. Certifier 1 Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D46478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sumsetts Rel. dinten. mp 20735 AP/MO mp 10 reph

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

DEC 3 0 2005

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 841 DM **Physician** artin December 0.5 /Medical give street and number) 4a. Facility Name (If not institution, 4b. City, Town, or Location of Death 4c. County of Death Examiner VA Medical saltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F 166-16-2934 86 Director 11/12/1919 North Carolina Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at New Castle DE Claymont 1 X Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 730 Peach Tree Road 19703 **USA** deeth v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1942- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☑ Divorced 1943 Completed 16a Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Chrysler Assembly Line Worker 3+ 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Elizabeth M. Chappell William O'Connor Baker, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William O'Connor Baker Jr. 3 Colesbery Drive, New Castle, DE 19720 brother 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Delaware Veterans 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 01/06/2006 Bear, DE * 4 ☐ Donation 5 ☐ Other (Specify) Memorial Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Strano & Feeley Family Funeral Home Well Cleown 635 Churchmans Rd Newark, DE 19702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Friysician Pheumonia disease or condition resulting in death) month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Physician/Medical Examiner requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day ō Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ate has been sign page 2 should be 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼ No 24a. Was an autopsy 1 Yes 2 No To the Hospital or Attending Physicien: after death.

Director: After this certification by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 1 XInpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be within 24 hours after de To the Funerel Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number December 29, 2005 AU4176435 MI6678 MD 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD 21201 N GREENE 10 ST. MATHAD ITOYL MD

DHMH 17 Rev 1/2001

State Registrár 31. Date filed (Month, Day, Year)

2006

ORIGINAL

Correle

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiepe []

1 - For State Registras Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 6:00PM 26,2005 Reginald Willis Barrett December /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Annapolis Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 13,1928 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**∑**M 2□F 77 Yrs. Maryland Director 216-22-3034 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10c. City, Town or Location 10a. State 28e-f show other treumatic event, the Medical Examinar must be notified at Yes 2 □ No Maryland Anne Arundel Annapolis Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 5 238 21401 9 Bristol Circle United States permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene important: If item 27 is marked other than "netural", or items 23a any jinjury or other treumatic event, the Medical Exame per mater once. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: If Yes, Give Year or Dates: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) President Printing Company 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mabel Gertrude Housley James H. Barrett 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Angela B. Barrett / Wife 9 Bristol Circle, Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Mem.Gardens 12/30/05 Annapolis, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21 Signature of Funeral Service Licens 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANUER LUNG Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed, page 2 should be de þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 24 No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident hours after deat 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) á 4 Homicide filled in within 24 hours a To the Funerel C t 🔾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) npletely (Check only one) and manner stated. 29c. License number 29b. Signature and the of certifie 0 0 30. Name and address of person who completed cause of death (Item 28a) (Type, Print BRESTERTERO 24 KINS STANZEY Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/200

Registrar

DEC 2 8 2005

DHMH 17 Rev 1/2001

EVELYN

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Carolyn W. Cochran December 24,05 /Medical 5:40 m 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HCR Manor Care 11901 Georgia Ave Wheaton Montgomery 7. Age (In yrs. last birthday)
R6 Yrs. Months Days Hours Min. Feb 05 5. Social Security Number **Funeral** 9. Birthplace (State or Foreign 1□ M 2□ F Laurinburg N. 230-30-9445 Director Usual Residence of Decedent death with the Marylend 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show r then "natural", or items 23a or 28a-f sho The Medical Examiner must be notified at Md Montgomery Wheaton 1 Ves 2 □ No Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 11901 Georgia Ave 20902 USA Funeral 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours efter 1 ☐ Yes 2X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: ð Specify: Black 3X Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Peges 1 end 2 should be filed within Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then eny Injury or other treumatic event, Ite Men Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martin Pate Annie Mae Quick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Gail Lee (Daughter) 5018 57th Ave #Apt C7 Bladensburg Md. 20710 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State Harmony Memorial ParkDec 29,05 Landover Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Tyrone J. Young 719 Kennedy St. NW 20011 21. Signature of Funeral Service Licenses Washington, DC 23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner attending physician end for use es the buriel-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy Completed hes 1 Tes 210 No 1 ☐ Yes 2 ☐ No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Tyes 2 To No ို 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 5 Pending efter death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide To the Hospital within 24 hours To the Funerel I Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certific 29c. License number 30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print) 2309 SHOKEFIELD ROAD, WHEATON SHASHANK 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

Registrar

DEC 3 0 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** Marie December 27, 2005 Casazza 11:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 226-20-3646 82 November 21, 1923 Director Virginia Usual Residence of Decedent with the Marylend 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Maryland Prince George's Temple Hills 1 ☐ Yes AXXVo Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 3612 Riviera Street 20748 USA Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status filed within 72 hours efter 1 ☐ Yes 2/21 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Home other permit. Peges 1 and 2 should be flie Department of Health and Mental Hy Importent: If Item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Novello Elizabeth Greco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan E. Koliopoulos / Daughter 3213 Marcando Lane Upper Marlboro, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec. 31, 2005 Resurrection Cemetery Clinton, Maryland 22. Name and Address of Facility George P. Kalas Fineral How P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745 21. Signature of uneral Service Licensee alsa Approximate Interval Between Onset and Death or complications that can sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. P.or. Enter the disease, or com-nock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) CANCER OF THE LARYNX WITH METASTICES years **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed the burial-transit **Bnd** Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physicien Physician/Medical use as the ettending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? as been signe 2 should be c þ 3€Probably 4 □Unknown 1 ☐ Yes 2 ☐ No. Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has autopsy performed? 1 ☐ Yes XX No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 X Inpatient Other: 1 ☐ Yes 2 🕱 No Certification: To 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 XNatural 5 Pending 1 Tyes 2 No investigation 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital vithin 24 hours e 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-18545 December 29, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 12070 Old Line Center Waldorf, Maryland 20602 P. Wisotsky 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

DEC 3 0 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day Year DECEMBER 26 2005 **Physician** CAMPBELL 3:30 A M EVELINE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | April 1 7 1940 | SOUTH CAROLINA 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖾 F Yrs. 220-38-1577 65 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Items 23a or 28a-f ehow traumatic event, the Modical Examiner must be notified at 1X Yes 2 □ No Funeral Director PRINCE GEOEGE'S FT. WASHINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20744 U.S.A. 12301 DENDRON PLACE Pages 1 and 2 should be filed within 72 hours after death a nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other then "natural", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE HOUSE KEEPER 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) RUSSELL CHRISTINE ULYSIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is eny injury or other trau once. 12301 DENDRON PL. FT. WASHINGTON, MARYLAND 20744 GARNET DORN/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ② Cremation 3 ☐ Removal from State 1/7/2006 RIVERDALE, MARYLAND RIVERDALE CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 na 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Shuck **Physician** se. Lunds disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): use as the burial-transit Hospital or Attending Physician: The law requires thet the death certificate be executed the attending physicien and Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Anoxic Exceptalopaly 1 Yes 2 No 3 Probably 4 Unknown Failure Vertilatu Dependenta. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 2 No certificate Spine dislocation Cenvica 1 ☐ Yes 2 🗆 NO funeral director. 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical completely (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D01852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 403 Queensery Rd Huttsville MD 20181 1 31. Date filed (Month, Day, Year) . Registrar's Signature State 3 0 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ROBERT E. CARTER DECEMBER 28 2005 3:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE HARFORD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F 76 Yrs. Director 248-44-8178 Sept 20. South Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r then "natural", or iteme 23a or 28a-f show the Medical Examinant by modified at 10d. Inside City Limits 1 X Yes 2 ☐ No Director Maryland Harford Havre de Grace 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 415 Market Street 21078 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 1947–50 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Forklift Driver 4 Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be fill ment of Health and Mental H tent: If item 27 is marked other. Clarence Levie Carter Jewel Oquinn ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra L. Carter / wife 3413 Abantowne Way, Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 5 permit. Page Department o importent: if any injury or R.A. Ferris & Co., Inc * 4 ☐ Donation 5 ☐ Other (Specify) 12/30/05 West Chester, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lisa Scott Funeral Home, P.A. 552 Lewis Street, Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine physicien and s the burial-translt resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Box (23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to deathout not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy 1 Yes Division of Vital or Attending Physician: Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၟႄ 3□ DOA Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date 1 kuun 28d. Describe how injury occurred Certification: 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No Director 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier THORNAS 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State Registrar

28.05

State of Maryland / Department of Health and Mental Hygiene For State Registrat Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 4:58 P N Physician George James Coleman, Jr. DECI 25 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Anne Arundel Medical Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**⊠** M 2□ F 420-10-1760 Yrs 87 Nov. 14, 1918 Alabama Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State rthan "natural", or Itame 23a or 28a-f ahov the Medical Examinar must be notified at Annapolis 1 ☐ Yes 2X No Maryland Anne Arundel Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 U.S.A. 1019 Boom Court death v 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. within 72 hours after 1 x x es 2 No If Yes, Give Year or Dates: 1940–62 1 Never Married 2XXMarried White 1 ☐ Yes 2XXXNo Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) at Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Aviator U.S. Navy 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If item 27 1e marked ofth any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Bessie Clark George James Coleman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1019 Boom Court Annapolis, Maryland 21401 Geneva Coleman/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 12/29/2005 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ACUTE MYOLARDIAL INFARCTION /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Year Month 4☐Pregnant at time of death 5 Other (specify) be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown SEVERE CARDIOMYOPATHY Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CHRONIC OBSTRUCTIVE PULMONARY DISEASE 24a. Was an autopsy performed 1 Yes 2 2 No within 24 hours after death.

To the Funeral Director: After this certitic completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DEC 27, 2005 monego D57531 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8601 Veterans May Suite 204, Millersonille, My 21108 Mohit Negs 31. Date filed (Month, De Year) 32 Registrar's Signature State Registrar **DEC 28 2005**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2:20PM Harold Cuff Dec. 23 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Wicomico Salisbury Salisbur Rehab + Nursing Ctr 8. Date of Birth (Month, Day, Year) Mar. 24,1949 If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In yrs. an birthday) 5. Social Security Number **Funeral** Days Hours Min 1XM 2□F Yrs. 56 Mar. New Jersey 148-40-5630 Director Usuat Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a. State 27 is marked other then "naturel", or items 23s or 28s-f show traumatic event, its Medical Exertine mount be notified at 1X Yes 2 □ No **Funeral Director** Maryland Wicomico Salisbury Pages 1 and 2 should be filed within 72 hours after death with the nent of Heelth and Mental Hygiene. 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 200 Civic Avenue 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1966— 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Farm Labor Agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Unknown) Helen Holoscoff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Heelth a Important: If itsm 27 is any injury or other trat once. P. O. Box 355, Parsonsburg, MD 21849 Mary Willey/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Crematory of Delmarva 12/24/2005 Delmar, Delaware 21. Signature of Juneral Septik Zeller Funeral Home, 1212 Old Ocean City Road 0. Box 3171, Salisbury, MD 21802 a. Pa 1. Enter the disease, or complic stock, or heart failure. List only ic dions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, see cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 900disease or condition resulting in death) Krone /Medical Due to (or as a consequence of) Examiner 100 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, clan/Medical as the ettending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) the detached Physi 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 res 2 No 3 Probably 4 Unknown icete has been siç 1, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 10 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) After t Certification; 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Destritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. (Check only one)

To the Hospital or Attendin, within 24 hours after death.
To the Funersi Director: Att completely filled in by the fun

Dr. William Robins 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar DEC 29 2005

20

29b. Signature and title of certifier

30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) Civic Ave Salisbury MD 200

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 3 0 2005

Physicia	an	For 12-30-05 PCC Registrar Amend#'sl_PerProceedings Name (First, Middle, Last)	TATAL STREET	Certificate of	Death	Reg. No.	7000 4007		
/Medic Examin Funeral Director	er	ta. Facility Name (If not institution, give s Montagonery 5. Social Security Number 6. Sec 36-10-1057 100 Usual Residence of Decedent	Gen. Hospi	4b. City, Town, birthday) If Under 1 Yea Months Day	or Location of Death If Under 14 Hrst 8 Hours Min.	Date of Birth, (Month, Day) Year	9. Birribiace (State or Fore Country)		
natural', or Itema 23a or 28a-1 show	Director	10a. State 10b. County Maryland Montgomery 10e. Street and Number		ver Spring 10f. Zip Code			10d. Inside City Lim 1 ☐ Yes 2X☐ I		
"natural", or Itema 23	by Funer	1 Never Married XX Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2(2)No If Yes, Give Year or Dates:	1 ☐ Yes X XN	f Hispanic Origin? (Specuban, Mexican, Puerto Ri do Specify:	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
iene. r than	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		life. DO NOT use reti	ne during most of working	· 1	BOEW		
e d a	Be	17. Father's Name (First, Middle, Last) Edward J. France St 19a. Informant's Name/Relationship (Ty)	De, Print)	-	Bessie B.	Hawkins Route Number, City	or Town, State, Zip Code)		
Dep innent of Health and Mer important: If item 27 is marke any injury or other traumatic pncs.		Richard France/ So 20a. Method of Disposition 1 Burial 243Cremation 3 B 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	emoval from State 20b. Place ceme Fort		natory 12/29	0/05 Bren Lincoln	ntwood, MD Funeral Home		
nysician Medical xaminer e pruial-trausit	Examiner	23a. Part . Enter the disease, or compliance, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cations that caused the death. Che cause on each line. Long (F Due to (or as a consequent Due to (or as a consequent Due to (or as a consequent	on not enter the mode of confluence ce of): HEALFA ce of):	lying, such as cardiac or		Approximate Interval Betweet Onset and Deat		
e attending phy	hysician/Medical								
ite has been signed by the	þ	Part II. Other significant conditions con	ntributing to death but not resultin	ng in the underlying cause	given in Part 1.	23e. Did tobacco	o use contribute to the cause of death 2 No 3 Probably 4 Unkn 24b. Were autopsy findings ava		
	Be Completed	25. Was case referred to medical examiner?	Hospital:	/Outpatient 3□ DOA	26. Place of Death	autopsy performed? 1 Yes 2 1 (Check only one)	prior to completion of cause death? 1 Yes 2 No		
After this funeral di	Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	8d. Describe how in	and Number or Rural Route Number,					
within 24 hours after death To the Funeral Director: completely filled in by the	edical Ce		sicien: To the best of my knowle iner: On the basis of examination and manner stated.				(s) and manner as stated. Ind place, and due to the cause(s)		
within To the	Me	29b. Signature and title of certifier	grus	29c. Lic		Date signed (Month, Day, Year) REMBER 26, 2009 MJ 20832			
7	E	30. Name and address of person who c	ompleted cause of death (Item 23	sa) (Type, Print)					

(5)	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiane Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 **Physician** 23 - 05 CHARLES v. FLOYD 3:30 A.M. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner STIVER SPRING MO If Under 1 Year 17 Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 4-10-1945 MONTGOMERY

9. Birthplace (State or Foreign Country)

45 LUMBERTON, N.C 13222 DAUPHINE ST.,
5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral 1 ☐ M 2 ☐ F 60Yrs. 239-70-7767 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location show 10d. Inside City Limits r than "natural", or items 23a or 28a-f shouthe Madical Examiner must be notified at 1X Yes 2 □ No Director MONTGOMERY MD SILVER SPRING 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? DAUPHINE ST., 13222 20906 UNITED STATES Funerai 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. ☐Yes 2½ No Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: BLACK Specify: <u>چ</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th MACHINE OPERATOR PRIVATE ind Mental Hygie marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALBERT FLOYD RETHA GERALD ဥ nt of Health and N: If Item 27 is man 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBORAH FLOYD/WIFE 13222 DAUPHINE ST. SILVER SPRING, MD. 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot once. 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT. OLIVET CEMETERY 12-29-05 WASHINGTON, D.C. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CAPITOL MORTUARY INC. 1425 MARYLAND AVE., N.E. WASHINGTON, D.C. 20002 Liller plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death **Physician** ancreatic Cancer, Metastatic /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and s the burial-transit or Attending Physicism: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): esn Division of Vital Records, P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medicai Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours af er de th. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier L, MD MD 035798 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARVINDER 31. Date filed (Month, Day, Year) DEC 3 0 2005

SINGH, ND, WHC 110 IRVING ST, NW, WASHINGTON,D

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 15 For State Registra Certificate of Death 2 Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** ECEMBER 37 2005 6.55AM Virginia Doris Flynt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Doctor's Community Hospital Lanham If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Min 1 □ M 2 🗓 F Yrs 225-40-3326 70 Sept. 11, 1935 Kentucky Director Usual Residence of Decedent the Maryland 10b. County 10c, City, Town or Location 10a State 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No Directo Maryland Prince George's Mount Rainier 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 3809 30th Street Items 23a 20712 U.S.A. Completed by Funeral I be filed within 72 hours after death nat Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Named 5 1 ☐ Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked Clarence Shadrick Pauline Pruitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if item 27 is eny injury or other tra-Johnnie Senior - Granddaughter 3809 30th Street, Mount Rainier, Maryland 20712 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 12/31/2005 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Sign turn of Emeral Service Licensee 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NON HODGKINS Physician LYMPHONA. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, DIABETES MELLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 Yes 2 D 2 ER/Outpatient Certification: To 1 Dinpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending after death. 1 □Yes 2 □No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 4 Homicide filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00058290 MD 30. Name and address of person who complet cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

HITATTUM

32. Registrar's Signature

31. Date filed (Month, Day, Year)

DEC 3 0 2005

4203 QUEENSBURY RD. HYATTSWILLE,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 1 15 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 03; 43AM **JAMES** Ι FARROW 28, 2009 December /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CECIL ELKTON UNION HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Min. 1 € M 2 □ F Days Hours 57 Yrs. 1948 PHILADELPHIA, 221-34-0551 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County r than "natural", or items 23a or 28a-f shovithe Medical Examinar must be notified at 1 X Yes 2 □ No ELKTON CECIL Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21921 U.S.A. 101 HICKORY LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ∰Yes 2 □ No If Yes, Give Year or Dates: 1967 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc filed within 72 hours after 1 ☐ Never Married 2 X Married 21215-0036 1 ☐ Yes 2X No Specify: Specify WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) **CARPENTRY** CARPENTER 12 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If item 27 is marked oth any injury or other traumatic event **ISABELLA** MADISON Τ. **FARROW JAMES** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ELKTON, MD 21921 FARROW/ WIFE 101 HICKORY LN YOT. L Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/30/2005 MAYERDALE CREMATORY NEWARK, DE * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service L 22. Name and Address of FacilitySPICER-MULLIKIN FUNERAL HOMES INC 1000 N DUPONT HWY NEW CASTLE, DE 19720 235 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction Proysician Acute mmedicte /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-transit and Due to (or as a consequence of): attending physician Physician/Medical the 8 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes of Vital 25. Was case referred to medical examiner?
1 ☐ Yes 2 No funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ✓ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28b. Time of Certification: After Division 5 Pending investigation 1 Natural al or Attendin s after death. Il Director: Af 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a To the Funeral C tik Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 28, 2005 17 arkos. and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

K65 (Month, Day, Year) 3 0 2005 1105

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 05 43528

30.0		For State Registrar 1. Decedent's Name (First, Middle,	Last)		Certifi	oute or	Douth	2. Date of Dea			3. Time of Death		
Physici		DIANE OLA FR						Decemb	ser 29	Year 3005	0607		
/Medi Examir	_	4a. Facility Name (If not institution,)	4b	. City, Town, o	or Location of Death		4c. County	of Death			
***	40K.E	PANIAGIA REGIO	Wat Medica	1 Cont		ن	19/13/14			com			
Funeral Director		5. Social Security Number 219–60–2090	6. Sex 7. A	ge (In yrs. last bi		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	3. Date of Birth	, Year 951		place (State or Foreig RYLAND		
and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	n or Location	on					10d. Inside City Limit		
Maryland I ehow	to	T CIM	TALBOT		EAS	STON					XX Yes 2□N		
r death with the Marylar tema 23a or 28a-1 ehow er must be collified at	al Director	10e. Street and Number 29354 WILL STE	REET		1	Of. Zip Code	21601		10g. Citizen of V	What Cou	ntry?		
USO urs after deat al', or Itema?	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Tyes 2 If Yes, Give Year or Dates:	?] No	i	Decedent of list, specify Cub	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Blac	e - Ameri ck, White			
re, Maryland 21215-0030 s 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. tem 27 is marked other than "natural", or ite other traumatic event, the Madical Examina	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)			(Give kind	s Usual Occu f of work done NOT use retire	during most of wor	rking	16b. Kind of B		•		
d with	E O	12	1	3.7	LINEW	ORKER			MANUFA		ING		
laryland 212 2 should be filled within and Menta Hygiene is marked other than aumatic event, the Manager is a market of the Manag	Be	17. Father's Name (First, Middle, L	_ast)					ne (First, Middle, OUISE RE		ne)			
aryia should t ind Ment marked umatic	ဥ	JOHN HANES								04-4- 7	- O- /-)		
Maryland of 2 should be fill the and Mental H 27 is marked out		19a. Informant's Name/Relationsh			•		rand Number or Ru TREET, EA			State, Zi	p Code)		
e, IV 1 and Health em 27 ther tr		LARRY C. FRAMI 20a, Method of Disposition	PIUN/ HUBBAN	20b. Place	of Dispositio	n (Name of		Date Date	20c. Location	City or T	own, State		
Baltimore, M permit. Pages 1 and 5 Department of Health importent: If item 27: any injury or other tra		1 Burial 2 Cremation 4 Donation 5 Other (Sp	pecify)	a	PEAKE		TION CTR.				VILLE, MI		
Departition of the policy of t		21. Signature of Funeral Service L	MERCE		200	S. HA	ess of Facility HELFENBEI RRISON ST	' EASTON,	MD 216	RAL 01	HOME PA Approximate Interval Between		
Physician		shock, or heart failure. List of Immediate Cause (Final	disease or condition										
/Medical Examiner		resulting in death)	Due to (or a	as a consequence	*****						12		
4.74	<u>-</u>	Sequentially list conditions, if any, leading to finite-diata cause. Enter Underlying	b. Due to (or a	cu / cur	offe S	ceie					1 6		
uted I	Examiner	Cause (Disease or injury that initiated events c.											
Box 68760, eath certificate be executed attending physician and for use as the burial-transit	edical Exa	resulting in death) Last Due to (or as a consequence of): d.											
OX 68 certificat nding phy use as th		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		- 2□E-					ite of deli	•		
P.O. BOX that the death cer ed by the attendir detached for use	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal deal at time of death		topic pregnant her (specify)			Mo	onth	Day Year		
cords, P w requires that been signed t should be deta	ρ	Part II. Other significant condition	ns contributing to death	but not resulting	in the unde	rlying cause g	iven in Part I.		obacco use con Yes 2□No		the cause of death?		
2 s a	Completed							24a. Was auto perfo 1 ☐ Yes	an 24b. osy ormed? 22 No	Were aur prior to d death? 1 \(\text{Yes}	topsy findings availa ompletion of cause 2 No		
Vital F Ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?						ath (Check only	one)				
of V Physic this ce al dire	은	1 ☐ Yes 2 🖔 No		tient 2 ER/C		3 DOA		Home 5 ☐ Resi			afy)		
ision of Vital Re trending Physicien: The death. ctor: After this certificate he y the funeral director, page	Certification:	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	gation]Yes 2 □No		how injury occur				
Divis	Certific	3 ☐ Suicide 6 ☐ Could (4 ☐ Homicide determ	inad 286. Place UI	Injury - At home, etc. (Specify)	farm, street,	factory, office)	28f. Location (City or To	Street and Num. wn, State)	ber or Hu	ral Route Number,		
Division To the Hospitel or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the tu	Medical	29a. Certifier 1 Certifyin (Check only one) 2 Medical	ng Physician: To the be Examiner: On the basis and manner	of examination	ge, death oc and/or inves	tigation, in my	opinion, death occ	e, and due to the urred at the time,	date and place,	and due	to the cause(s)		
To ti withi To ti	Σ	29b. Signature and title of certifie	r				rse number		29d. Date signe				
•		1/1/				12-11	0547	9 21	17/2	9/2	5		
/		30. Tame and reduces of person		f death (Item 23a) (Type, Pri		w.	7:	×		Tion. 11		
1-			1 ford										

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere [] [] 5 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Melba Virginia Fee 0600 05 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HICOMICO Peninsula 54/156414 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** 1 ☐ M 2**X** F Days Hours Yrs. 68 Director 234-58-9732 Feb. 17, 1937 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28e-1 show other traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Iteme 23a 1514 Riverside Drive Apt. C312 21801 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: ģ 3 ₩Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 73 h and Mental Hygiene.
7 Is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Pre-School Teacher Education 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ray Allen Wyant Mary Simms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Deportment of Health at Important: If item 27 is any injury or other traugonce. 748 Hemlock Street Salisbury, MD 21804 Terrie Mahoney (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Springhill Memory 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec. 31, 2005 Hebron, Maryland 22. Name and Address of Facility Short Funeral Home Delmar, DE 13 East Grove St. 23a. Part1. Enter the tisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Caroliac **Physician** 20mi /Medical Due to (or as a consequence of): Examiner Poranou Sequentially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 Ø No Month 4 Pregnant at time of death 5 Other (specify) Records, P.O. Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No Division of Vital 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Hospitel or Attending P
 24 hours after death.
 Funerel Director: After t Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 ANatural 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours a To the Funerel E 1 rentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Cneck only one) 29b. Signature and title of certifier Kaw KA

DHMH 17 Rev 1/2001

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 120A M GREGORIO (NMN) GONZALEZ DECEMBER 27 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner National Institutes of Health Bethesda Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 MM 2 □ F Yrs Director 33 1972 Mexico June 26. None Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or Items 23e or 28e-f show the Medical Examiner must be notified at 1AYes 2 □ No Directo MD Baltmore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2002 Portugal St. 21231 Funeral Mexico 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 √2 Yes 2 □ No Specify: Specify: Hispanic Be Completed by Mexican 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7th Waiter Calisco Restaurant es 1 and 2 should be filed vol Health and Mental Hygie of Health and Mental Hygie filem 27 is marked other to other treumatic event, to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Herlindo Gonzalez Angela Neponoceno Malpica 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health ant: If item 27 i Alicia Hernandez/Wife 2002 Portugal st Baltimore, MD. 21231 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) 12-30-2005 Velatorio Del IMSS Guerrero, Mexico 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
Marshall's Funeral Home, inc. 4217 9th St. N.W. Washington, D.C. _ 20011 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Pan1. Enter the disease, or com hock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARREST ARDIOPULMONARY **Physician** /Medical Due to (or as a consequence of): Examiner PROGRESSIVE MYELOID ONE YEAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physicien and Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? Year Day signed by the a d be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by as been sig 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? page 1 ☐ Yes 2 ☑ No certificate 2 👿 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပို 1 Nonpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death the f 6 Could not be 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 61950

the

The law requires that the death certificate be executed

or Attending Physicien:

Division of Vital Records, P.O. Box 68760,

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) State DEC 3-0 2005 Registrar

SHIVANI

Shwards



Drivanava

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

		1	FOR	artment of Health and Me	ental Hygien Reg. N	711115 17531
	Physicia		Decedent's Name (First, Middle, Last)		2. Date of Death Month December	3. Time of Death 25, 2005 8:00 p M
	/Medic Examin	al _	JOHN MARTIN GARRITY 4a. Facility Name (If not institution, give street and number) Bowie Health Center	4b. City, Town, or Location of Death	4	c. County of Death Prince George's
	Funeral Director		5. Social Security Number 6. Sex 1 $\overset{?}{\boxtimes}$ M 2 $\overset{?}{\square}$ F 79 Yrs.) If Under 1 Year If Under 24 Hrs. 8	B. Date of Birth (Month, Day, Year May 4, 19	9. Birthplace (State or Foreign Country)
	show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L.			10d. Inside City Limits 1 ∑Yes 2 □ No
	vith tha M	Direc	Maryland Prince George's Cheverly 10e. Street and Number	10f. Zip Code		Citizen of What Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic avant, it is Medical Examination in this indiffication.	by Funeral I	6404 Inwood Street 11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No 1944— If Yes, Give Year or Dates: 1946	20785 Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerlo R 1 ☐ Yes 2 ☒ No Specify:		S.A. 14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	within 72 hoursens. than "natural in Medical Expension of the control of the cont	Completed t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) nt Management Analysi	Un	Kind of Business/Industry ited States vernment
and 2	d be filed ental Hygis cad other c avant, L	To Be Co	17. Father's Name (First, Middle, Last) William L. Garrity		(First, Middle, Maide	
Maryland	12 shoul h and Me 7 is mark traumati	Ĕ	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ling Address (Street and Number or Rural	Route Number, City	
Baltimore, I	Pages 1 and nent of Health int: If item 2: iry or other		20a. Method of Disposition 1 ☑ Burial /2 □ Cremation 3 □ Removal from State 4 □ Donaron 5 □ Other (Specify) 20b. Place of Disposition cemetery, cree Cate of I	ematory or other place) Heaven Cemetery 12/29	20c. 9/2005 Si	Location - City or Town, State
Balti	permit. Departm Imports any inju			22. Name and Address of Facility Gas 4739 Baltimore Aven		
	Pnysician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Due to (or as a consequence of):		respiratory arrest,	Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
.O. Box 6	death certific e attending p od for use as	hysiclan/Med		□ Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Ω.	law requires that the de as bean signed by the a 2 should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the $Pulmonary \ Embolism$	underlying cause given in Part I.		o use contribute to the cause of death? 2 🖔 No 3 □ Probably 4 □Unknown
Vital Records,	9 4 9	Completed			24a. Was an autopsy performed 1 Yes 2 🔯	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
	Physician: Th this certificate ral director, pag	o Be (25. Was case referred to medical examiner? 1 Yes 2 XNo	26. Place of Death ent 3 DOA Other: 4 Nursing Hom		6 ☐Other (Specify)
ion of	ding h. After fune	atlon: T	27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work? M 1 □ Yes 2 □ No	8d. Describe how in	
Division	Difte o	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	24 h	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, developed the best of my knowledge	investigation, in my opinion, death occurre	ed at the time, date a	and place, and due to the cause(s)
	To the within 2 To tha complet	×	29b. Signature and title of certifier Brand, Mr)	29c. License number D26287		Date signed (Month, Day, Year) cember 28, 2005
R	-(13/11	a	30. Name and address of person who completed cause of death (Item 23a) (Type Michael Berard, MD 7305 Baltimore	e, Print) Avenue, #107, Colle	ege Park,	MD 20740
	St Regist	ate rar	31. Date filed (Month, Day, Year) DEC 3 0 2005	we -		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** P M December 28, 2005 Arabella Laura Geller 2:05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Arcola Health and Rehab Center Montgomery Silver Spring 8. Date of Birth (Month, Day, Year Dec 18, 1 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F 83 Yrs. 1922 Director 071-20-7627 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show Item 27 ie marked other then "natural", or Items 23a or 28a-f ehov other treumatic event, the Modical Examinar must be notified at 1 Yes 2 No Completed by Funeral Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20902 910 Arcola Avenue USA deeth 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No tf Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours effer onent of Heelth and Mental Hygiene. Int: if Item 27 ie marked other then "natural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dental Office 12 Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Emma Rosenblum Alfred Ronald ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3003 Bonview Lane Silver Spring, MD 20906 Seymour J. Ronald/brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State December 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If eny injury or spece. ö 30, 2005 Beltsville, Maryland 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service Liger MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final **Physician** gesty on disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner consequence of): use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medicai JE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. À should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 s hes autopsy performed? 22 No 1 Yes 1 ☐ Yes Hospitel or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death | Check only one examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other 4X Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 3 DOA this 28c. tnjury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending 1 Tyes 2 No within 24 hours after death.
To the Funerel Director: A
completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٥ 10 6. UX M.D 30. Name and address of person who completed car (ttem 23a) (Type, Print), 354 strar's Signature State Registrar

		1	For State Registrar	State of Maryla		artment of Hertificate of L		ental Hygier	11111	43533
			I. Decedent's Name (First, Middle, L	ast)				2. Date of Death Month	oay Year	3. Time of Death
	Physicia		Frank G.	Hall				r 31,2005 4:00p M		
	/Medic Examin		a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, or	Location of Death	4	tc. County of Dea	
			Laurelwood			Elkto			Ceci1	
	Funeral		, ooola, ooola, , , , , , , , , , , , , , , , , , ,	4EM 4FT	s. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea	ar) (inthplace (State or Foreign Country)
Н	Director	-	232-34-0682 Usual Residence of Decedent	1XM 2UF 77	113.			June 6,1	.928	VA
	land ow	-	10a. State 10b. County	10c. C	City, Town or Lo	ocation				10d. Inside City Limits
	Mary -1 sh	ţō	MD Cec	i 1	E1	kton				1 ☐ Yes 2 🙀 No
	r 28e	lrec	10e. Street and Number			10f. Zip Code		10g. (Citizen of What C	Country?
	23a o	a D	792 Pulaski	Hwy.		21921			S.A.	
	ems ermi	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	or it	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🗓 No	Specify:		Specify:	White
Ö	filed within 72 hours after death with the Maryland Hygiene. Wher then "naturel", or tlems 23a or 28e-f show ther, the Medical Examiner must be notified at	ed b	15. Decedent's		16a. Dece	dent's Usual Occupa	ation	16b.	Kind of Busines	s/Industry
5	n na	plet	(Specify only highest (Secondary (0-12)	grade completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of workii)	ng		
212	d with giene.	Completed	10	-	C	ustodian	1	Ge	eneral	Motors
힏	0 = 0 >	Bec	17. Father's Name (First, Middle, La	st)				(First, Middle, Maid		
<u>Ja</u>	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other then "naturet", or items 23a or 28e-1 show to marked other than "naturet", or items 23a or 28e-1 show to marked other than "nature".	2	Ulysses Hall					ie Smith		7. 0- 13
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship Ernest Hall/S					Route Number, Cit mington		. 9808
	permit. Pages 1 and 2 should b Department of Health and Ments important: If Item 27 is marked any injury or other treumetic e once.	1 /	20a. Method of Disposition		. Place of Dispe	osition (Name of			Location - City of	
Jor	Pages nent of h ant: If its ury or o		1 Surial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spe	Removal from State	cemetery, cre	matory or other place Cemetery	, yanua	- 1	Elkton,	МЪ
Baltimore,	artme artme ortant injury	1	21. Signature 5 Other (Spe		2	2. Name and Addres	ss of Facility	9		1110
Ba	permi Depa Impo any is		- The					uneral H		01001
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	respiratory arrest,	1, MD					
	Physician		Immediate Cause (Final	CHF						Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a cons	equence of):					
	Examiner		Se uentially list conditions.	b. severe						unk
ы,	p ±	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	equence of).					1.
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. CAD Due to (or as a cons	equence of):					vnK
8760,	death certificate be executed e attending physician and of for use as the burial-transit			200 (0) 03 2 03.13						
	physicate physics the	Physician/Medical		d						
9 X	eath certific attending p I for use as i	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of prec					23d. Date of c	delivery
Вох	death a atter	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o		□Ectopic pregnancy □ Other (s <i>pecify)</i> _			Month	Day Year
o.	that the de led by the a detached f	hys	9 Unknown	9□ Unknown						
ď.	requires that the leen signed by th hould be detache	by P	Part II. Other significant condition	s contributing to death but not i	resulting in the	underlying cause giv	en in Part I.			to the cause of death? Probably 4 Dunknown
ğ	v require been sig should b							1 🗌 Yes	2 No 3	Probably 4 Donknown
Vital Records,	aw as b	Completed						24a. Was an autopsy	prior t	autopsy findings available o completion of cause of
m	Th ate pag	Con						performed 1 ☐ Yes 2 ☑	No death	es 2□No
/ita	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	The exists		Oth		Check onl one		
of\	Physician: rthis certific ral director,	2	1 ☐ Yes 2 ☐ No		28b. Time		4 EM Maising Ho	me 5 Residence 28d. Describe how i		pecify)
N C	ding P h. After funera	lon	27. Manner of Death 1 ☑Natural 5 ☐ Pending		njury	Wor		200. 2000/100 11017	iqui y occurre	
isic		icat	2 Accident investiga 3 Suicide 6 Could no	ot be 280 Place of Injury - A	it home, farm, s					Rural Route Number,
Division	l or Attenation after deat Director:	Certification:	4 Homicide determin	building, etc. (Spe	ecify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town, S	tate)	
	To the Hospital within 24 hours of To the Funereil completely filled		29a. Certifier 1 Certifying	Physician: To the best of my	knowledge, dea	th occurred at the tir	me, date and place,	and due to the caus	e(s) and manner	as stated.
	n 24 the Fu	edical	(Check only 2 Medical E	xamme: On the basis of exam and manner stated.	ination and/or i	nvestigation, in my c	pinion, death occur			
	To the Hospital or within 24 hours after To the Funerel Direction completely filled in E	Σ	29b. Signature and title of certifie			29c. Licens	se number	29d.	Date signed (Mo	ontn, Day, Year)
)				1			1073	07	1 Jan	06
	7		30. Name and address of person		Item 23a) (Type	Christina March	s Call A	Lw Castle	00 10	720
	~	ate	31. Date filed (Month, Day, Year)	M O 32. Registrar's Si	s17	· .	10	LU LESTIE	- 11	, , , ,
	Regist		JAN 0 3 200	32. Registrar's Si	Goess	V				
					9/					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended 23a, 31 1- For per M.D., TCHD, 01/03/06, sbb Certificate of Death 43534 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death Month 23^{ay} 2085 **Physician** 9:15 AM SAMUEL HANCOCK HOPKINS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot Genesis HealthCare - The Pines Easton If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 XM 2 ☐ F 82 182-20-2233 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Medical Example transities at 1 Yes 2 □ No EASTON Director TALBOT MD 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code with 610 DUTCHMANS LANE 21601 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours efter 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE

Physician /Medical Examiner

use as the burial-trar

detached for

pe

funeral

after death.
I Director: Af

within 24 hours a To the Funerel C Hospitel

the

completely

the

ģ signed

peen

has page 2

requires that the death certificate be exect

or Attending Physiclen:

Division of Vital Records, P.O. Box 68760

Examine

Physician/Medical

Completed by

Be

2

Certification:

Medical

permit, Pages 1 and 2 a Department of Health at Importent: If Item 27 Is eny injury or other treu once

and Mental Hygiene.

Samuel Hopkins

þ

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months?

25. Was case referred to medical examiner?

1 ☐ Yes 2 No

27. Manner of Death

Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

□Yes 2□No

Immediate Cause (Final disease or condition resulting in death)

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

GRANVILLE B. HOPKINS

19a, Informant's Name/Relationship (Type, Print)

ROSANNE HOPKINS/WIFE

' 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

Joseph m.

15. Decedent's Education (Specify only highest grade completed)

1 Xurial 2 Cremation 3 Removal from State

Ustrowski

nethors Due to (or as a consequence of)

C.F.S.P.

Due to (or as a consequence of).

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

College (1-4or 5+)

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4☐Pregnant at time of death 9□ Unknown

3 Ectopic pregnancy 5 Other (specify)

M

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ST. DAVID'S CEMETERY 12/29/2005

22. Name and Address of Facility

TRUST MANAGER

20b. Place of Disposition (Name of

cemetery, crematory or other place

23d. Date of delivery Month Day

16b. Kind of Business/Industry

TRUST BANKING

20c. Location - City or Town, State

WAYNE, PA

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy

18. Mother's Name (First, Middle, Maiden Surname)

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA

HELEN HANCOCK

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

26344 ARCADIA SHORE CIRCLE, EASTON, MD 21601

200 S. HARRISON ST EASTON, MD 21601

Aspiration Pneumonia

Alzheimer's Demontia

Date

24b. Were autopsy findings available prior to completion of cause of death?

Approximate Interval Between Onset and Death

Year

dons

Weaks

2.1XN0 26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

Other: Nursing Home 5 Residence 6 Other (Specify)

28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

CROWLLY

Name and address of person who completed cause of death (Item 23a) (Type, Print)

o HIVA State

31. Date filed (Month, Day, Year) JAN 0 3 2006



MD

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 25 per doc 851 1-13-06 vt
State of Maryland Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician 14: 05 PM 05 Douglas Wilson Heare /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY SACRED HEART HOSPITAL CUMBERLAND If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 19, 1912 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months DOM 2 F 93 Director 233-60-3673 Usual Residence of Decedent 10b County 10c. City. Town or Location 10d. Inside City Limits 10a State is marked other than "natural", or items 23e or 28e-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director W Hampshire Romney 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code HC-63 Box 2320 26757 USA Funerai within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XXNo Specify Specify: White by 3XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Minister Baptist Church permit. Pages 1 and 2 should be fit.
Department of Health and Mental Hy,
Important: If Item 27 is marked
any Injury or other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ella May Shank 2 Robert N. Heare 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1457 Ledbetter Rd. Munford, ALA. (Son) Garland Heare 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 12/26/05 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Mt. Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Augusta, W 22. Name and Address of Facility McKee Funeral Home Inc. 21. Signature of Funeral Service License P.O. Box 270 Augusta, WV 26704 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final NEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit anding physicien and use as the burial-tran Due to (or as a consequence of): Physician/Medical Box (IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for u in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9 Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? certificate 1 ☐ Yes 21 No Division of Vital After this certification funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannes of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 20054004 anna Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumberland Kent avenue Khanna 625 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JAN 1 3 2006

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Renzo Frank Ischia Month December 26, 2005 1:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HCR Manor Care Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 101-07-5074 Director 86 Italy 11/20/1919 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show olical Examiner over be notified at DE New Castle Newark Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural; or items 23e or 3 ury or other traumatic event, it is Maries is a miner constitution or other traumatic event, it is Maries is a miner constitution. 214 Warfield Road 19713 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Field Electrician 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rudolfo Ischia Pia Miorelli ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Janet Brown/daughter 214 Warfield Rd. Newark, DE 19713 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department (Important: If any injury or once. All Saints Cemetery | 12/30/2005 Wilmington, DE `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Strano & Feeley Family Funeral Home Coluce 635 Churchmans Rd Newark, DE 19702 Moun 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Congestive heurt disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Dementic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Dav Year 5 Other (specify) be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part !. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 ☐ Yes 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death death 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HIRPARA wa 20176 100% 7505 TAYANT Dring 05/20 filed (Month, Day, Year) 32. Registrar's Signat State JAN O Registrar 2006

			1 - For State Registrar	State of Mary	-	artment of H			giene 0 0 5	43537
ž.	E.		Decedent's Name (First, Middle, Last	st)				2. Date of Dea	ıth	3. Time of Death
	Physici		Alfred	Jerry	Kish			Decembe	r 24, 2005	
	/Medic Examir		4a. Facility Name (If not institution, give		1011	4b. City, Town, or	Location of Dea		4c. County of De	
100	**		Southern Maryland 5. Social Security Number 6. S		yrs. last birthday)	If Under 1 Year	nton If Under 24 Hr	s. 8. Date of Birth	Prince G	irthplace (State or Foreign
	Funeral Director			X M 2□F	62 Yrs.	Months Days	Hours Mir	Feb. 21	r, Year) (nsylvania
	land low		10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits
	Ba-f eh	Director	Maryland Prince G	ieorge's	Clinton					1 ☐ Yes 2√CXNo
	or 2	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What (Country?
	e 23a	'a	7404 Dryden Place	10.144- 0	:- 11.0	20735		0	U.S.A.	and and tasks
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or iteme 23a or 28a-f ehow event, I've Medical Examinat must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ★ Divorced	12. Was Decedent Ever Armed Forces? 1 ⊠Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2🏿 No	ispanic Origin? (in, Mexican, Pue Specify:	specify Yes of No- rto Rican, etc.)	Black, Wh	nerican Indian, lite, etc. Ihite
8	tural	ed b	15. Decedent's Ed		16a, Dece	dent's Usual Occupa	ation		16b. Kind of Busines	
15	n ne	piet	(Specify only highest gra	de completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of w	orking		,
21215-0036	filed withi Hygiene. ther than	Completed	12	College (1-401 54)	Compu	iter Mech	anic		Computer	Repair
	al Hy d oth	Be	17. Father's Name (First, Middle, Last)		200		18. Mother's Na	ame (First, Middle,	Maiden Sumame)	
Maryland		2	Alfred Gabor Kish					ında Kure		
Mar			19a. Informant's Name/Relationship (Mary Kish - Moth			Dryden Pl			r, City or Town, State	, Zip Code)
	Heal		20a. Method of Disposition		Ob. Place of Dispo	sition (Name of		Date Place	20c. Location - City of	or Town, State
nor	50 ± 10		1 ☐ Burial 2 【Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific		•	matory`or other plac	1	31-2005	Und down	
Baltimore,			21. Signatur of Funeral Service Licer		Huntt Cre	IIId LUT'Y 2. Name and Addres		P.O. Bo	Waldorf,	maryland
Ba	permit. Departr importe any inju		I John Eli	de	Hu	intt Fune	ral Home		f, Marylan	d 20604
	Physician /Medical Examiner purish transit purish transit	il Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	ensequence of):		018SD (8	OURCC	THI DO	ALE YOU
8760	cate b	dical	•	_ d						
.O. Box 6	The law requires thet the death certificate be executed to has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
Δ,	res thet the signed by be detact	5	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.			to the cause of death?
orc	w require been si should I	eted								
Il Records,		Completed			<u> </u>			24a. Was a autop: perfor 1 Tes	sy prior to	
Vital	Physician: T this certificet ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		t all post Other	00	eath Check only or	100	
ot o	Phys this ral dii	2	1 ☐ Yes 2 🔼 No 27. Manner of Death	28a. Date of Injury	2 KER/Outpatier 28b. Time o	IL SU DOA	4 🖂 Nursing		ence 6 Other (Sp ow injury occurred	pecify)
Division	or Attending Fater death. Director: After in by the funer	Certification:	1 Autural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	(Month, Day Ye	nar) Injury	M 1 []	k? Yes 2 □ No			
DIV	tel or Attences after death	Certif	4 Homicide determined	28e. Ptace of Injury - building, etc. (S		eet, factory, office		City or Tow	itreet and Number or i n, State)	Hural Houle Number,
	To the Hospitel within 24 hours of To the Funerei I completely filled	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of m niner: On the basis of exa and manner stated.	amination and/or in	h occurred at the tim vestigation, in my of	ne, date and place pinion, death occ	ce, and due to the courred at the time, o	cause(s) and manner date and place, and di	as stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	and the same of th		29d. Date signed (Mo	
			1125		>	Di	8545	2	KERLBER	26, 2005
			30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print)	V2 22	1 NO 1	111.001	26, 2805 Md . 2860
W	1P2+1		1, WISOVSK	4MA). 1.	2010	ery Un	ie La	UTAK U	UHUBRIT	Ma Zeloù
	Sta		31. Date filed (Month, Day, Year) DEC 2 9	2005 32. Redistrar's	Signature	Costs			•	

		1 - For State Registrar			d / Departm Certific		alth and M	ental Hygie	9	43538
Physic		Decedent's Name (First, Middle, HOWARD W. KNIE						2. Date of Death Month	Day Y	3. Time of Death
/Medi- Examir		4a. Facility Name (If not institution, Memorial		tal	(City, Town, or Lo	IDN		4c. County of	
Funeral Director		5. Social Security Number 506-01-4164 Usual Residence of Decedent	7. A	ge (In yrs. Ia	Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) SEPT. 15	(ear) 1917	Birthplace (State or Foreign Country) NEBRASKA
Maryland a-f e-how	tor	10a. State 10b. County	вот	10c. City	, Town or Location OXFOR					10d. Inside City Limits X☐ Yes 2 ☐ No
death with the Maryland	Funeral Director	10e. Street and Number 301 BONFIELD A	VE.			f. Zip Code 216			g. Citizen of Wha	USA
Khieflers 5-0036 72 hours after death with the Marylan natural; or Itame 23s or 28a-f ehow	by	11. Maritaf Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceden Armed Forces Market Yes 2 [If Yes, Give Year or Dates:	? No		Decedent of Hisp , specify Cuban, es 2 XNo	anic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. WHITE
T C 1 3	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or	5+)	life. DO No	of work done dur OT use retired)	ing most of worki	ng 16	Sb. Kind of Busin	,
laryland 2:	Be	12 17. Father's Name (First, Middle, Li WILLIAM KNIER	,		ELECTRI	CAL ENG	3. Mother's Name	(First, Middle, Ma	,	ASTING
Maryla and 2 should and 2 should azt le marke	J.	19a. Informant's Name/Relationshi ELAINE J. KNIERI	p (Type, Print)				Number or Aura	FORD, MA	City or Town, Sta	
Ore Literature		20a. Mathod of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		, ce	lace of Disposition ametery, crematory	or other place)	1/5/2		ROSLYN,	y or Town, State
Baltimo Baltimo permit. Page Depurtment: If mportant: If any righty or		21. Signature of Funeral Service Li	Ostriciski		22. Nam	OWS, HE	of Facility		M FUNER	AL HOME PA
Physician /Medical Examiner		23a. Part1. Enter the disease, or c shock, or heart failure. List of fmmediate Cause (Final disease or condition resulting in death)	a. <u>Can du d</u> Due to (or a	line. Le de s a consequ	srhyte	mia				Approximate Interval Between Onset and Death MINUTES
760, te be executed ysician and e burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <u>Klart</u> Due to (or a	Schen	20515					years
14 2 2 4	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcom 1 Live birth 4 Pregnant a	e of pregnar 2 🗌 Fetal	ncy death 3□Ector	pic pregnancy or (specify)	10h	7111111	23d. Date o	f delivery Day Year
Ords, P.	by	Part II. Other significant condition	s contributing to death				in Part I. Well NO	1 ☐ Yes	cco use contribu	te to the cause of death? Probably 4. Jonknown
Vital Rec sician: The law certificate has b lirector, page 2 s	Completed	ny so thyrord	disn			<i>i</i>		24a Was an autopsy performe	prio dea	e autopsy findings available r to completion of cause of th? Yes 2 \sum No
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director. page 2 should be detached for use as the	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1. Natural 5 Pending investigal	28a. Date of Inj (Month, D	ury	ER/Outpatient 36 28b. Time of Injury	DOA Other: 28c. Injury at Work?	4 Nursing Hor	ne 5 Resident		Specify)
DIVIS tel or Atters after de	Certification;	3 Suicide 6 Could no 4 Homicide determin	building, e	tc. (Specify				City or Town,	State)	or Rural Route Number,
the Hospi iin 24 hou iin 54 hou in 51 hou in 1916 tely fill	Medicai	one)	Physician: To the bes xaminer: On the basis and manner s	of examinat	wledge, death occu ion and/or investig	ation, in my opini	on, death occurre	ed at the time, date	e and place, and	due to the cause(s)
To To To Coor	2	29b. Signature and title of certifier 3 Seymu	mno			29c. License n		De	I. Date signed (A	Month, Day, Year) - 29, 2005
(12+1VA		30. Name and address of person w	no completed cause of	death (Item	23a) (Type, Print) Uild AL	enve	Easto	n M	> 211	29, 2005
Sta Regist	ate rar	31. Date filed (Month, Day, Year) JAN 0 3 2	32. Regis	trar's Signat	nte					

			1 ~ For State Registrar	State of Maryla	nd / Depa	artment of H rtificate of	lealth ar Death	nd Men	tal Hygie	Lie V V	5	43539
	Physici		Decedent's Name (First, Middle, Last) ROBERT JOSEPH LY	NCH					Date of Death Month EC. 27,	Day 2005	Year	3. Time of Death 7:00 a M
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of			4c. County of	of Death	1
п			6005 Jamestown Ro	oad		Hyatts	sville			Prince	e Ge	orge's
	Funeral		5. Social Security Number 6. Sex	Cu off	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hours		Date of Birth Month, Day, Ye	ear)	9. Birth	place (State or Foreign
	Director		379-24-9996	78	Yrs.			I	Month Day Y	27	Vew	York, NY
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation					1	10d. Inside City Limits
	f sho	ō	Maryland Prince Ge	eorge's	Hvatt	sville						1 XYes 2 No
	the 28a-	Director	10e. Street and Number	50186		10f. Zip Code		-	10a.	Citizen of W	hat Cour	ntry?
	3a or	0	6005 Jamestown Roa	ad		1111	782			USA		,.
	ms 2	era		12. Was Decedent Ever in	U.S. 13.	Was Decedent of H		n? (Specify	Yes or No-	14. Race		can Indian,
9	or Ita	Ē	1 ☐ Never Married 2 🛣 Married	Armed Forces?	94/ -	f Yes, specify Cuba 1 □ Yes 2 █️No		Puerto Rica	n, etc.)		, White,	etc. hite
93	ral',	2 by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1951	TES ZLANO	Specify:			Specify:	VV.	litte
S O	72 h	Completed by Funeral	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Deced (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most o	of working	168	. Kind of Bus	iness/In	dustry
12	vithin ne. han	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	1	<i>DO NOT</i> use <i>retire</i> ostal Ser				IIS Co	1170r	nment
2	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Itams 23a or 28a-f show ant, the Medical Evantiver must be notified at	ပိ	17. Father's Name (First, Middle, Last)		1	ostal bel		e Name /Fin	st, Middle, Mai			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked othar than "natural", or Itams 23a or 28a-f show any injury or othar traumatic evant, the Medical Evant are must be notified at ance.	o Be	John Edward Lynch						Glennor		,	
$\overline{\geq}$	Shoul od Me mark	2	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	ng Address (Street	and Number	or Rural Ro	ute Number, C	ity or Town, S	tate, Zip	Code)
<i>®</i>	nd 2:		Audrey G. Lynch -	Wife	6005	Jamestov	m Road	d, Hya	ttsvil]	Le, MD	20	782
re,	s 1 a of Hea ltern otha		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other place	ne)	Date	200	. Location - C	ity or To	own, State
altimore,	Page nent c int: If		1 ABurial 2 □ Cremation 3 □ Ro `4 □ Donation 5 □ Other (Specify)	anioval noin State		n Cemete		2/30/2	2005 В	rentwo	od,	Maryland
ä	rmit. spartn ports y inju		21. Signature of Funeral Service License	98	22	. Name and Addre	ss of Facility	Gasch	's Fune	eral Ho	ome.	P.A.
<u> </u>	82 = 8		Hallune Hard	11013	73 4	739 Balti	more A	Avenue	, Hyatt	sville	, M	D 20781
			23a/ Part1. Enter the disease, or coredinates shock, or heart failure. List only on	eations that caused the deale cause on each line.	ath. Do not ent	er the mode of dyin	ng, such as ca	ardiac or res	piratory arrest,			Approximate Interval Between
1	Pnysician		Immediate Cause (Final disease or condition	Melenoma								Onset and Death months
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):						-	
6		<u></u>	Sequentially list conditions, b	. Due to (or as a conse	Mulanca of).							
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Duo to (o. 23 2 conso	19001100 01).							
,	exect n and ial-tra	Examiner	that initiated events cresulting in death) Last	Due to (or as a conse	quence of):							
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai	d									
9	ng ph as th	Nedi	IF FEMALE:									
Вох	eath certific attending p	an/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet		Ectopic pregnancy	,			23d. Date		
о. П	at the dea by the at tached fo	Physician/Me	1 Yes 2 No	4□Pregnant at time of 9□ Unknown	death 5□	Other (specify)				Mont	п	Day Year
0	hat th od by detacl	Phy	Part II. Other significant conditions con	tributing to death but not re	sulting in the m	ndarking cause giv	en in Part I		23e Did tobac	o use contrib	uite to th	ne cause of death?
Records,	uires that signed b	d by				racing access give	o,, ,,, ,		1 ☐ Yes	_		ably 4X Unknown
Sor	w require been sli should b	lete						—	24a. Was an	24b W	ara auto	psy findings available
	The lav ate has page 2.	Completed						_	autopsy performed	Dri	or to cor ath?	mpletion of cause of
Vital	dclan: Th certificate rector, pag	0	25. Was case referred to medical		· · · · · · · · · · · · · · · · · · ·		26 Place of		eck only one)	No 1L	Yes	2∐ No
<u> </u>	ysician: is certific director,	O B	examiner?	ospital: 1 Inpatient 2	☐ ER/Outpatien	t 3□ DOA Oth			5 Residence	6 □Other	(Specify	v)
0	ding Phys h, After this funeral di	n: T	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		y at		Describe how i			
<u> </u>	tandir Jeath, tor: Al the fu	atic	2 Accident investigation				Yes 2 □ No)				
Division of	for Attanation after deati	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, stre cify)	eet, factory, office		28f. L	ocation (Stree: City or Town, S	t and Number tate)	or Rura	l Route Number,
	pital ours a aral [al Ce	29a. Certifier 1 A Certifying Phys	ician: To the best of my kn	Soulades death	and the King		-1		(-)	- 5	
	To the Hospitel within 24 hours a To the Funeral I completely filled	edica	(Check only 2 Medical Examin	er: On the basis of examinand manner stated.	ation and/or inv	restigation, in my o	pinion, death	occurred at	the time, date	and place, an	d due to	the cause(s)
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director,	Me	29b. Signature and title of certifier		-	29c. Licens			29d.	Date signed (Month,	Day, Year)
6	31) ('Mea	M MW		Д47	654			14/29/	ZUU:	,
(10) Wa		30. Name and address of person who con				11. 1	w an	782			
	/		Charlotte Dean 31. Date filed (Month, Day, Year)	6525 Belcre	and and		ттте, 1	40 س	702			
	Sta Registr		DEC 3 0 2005	2. Registrar's Sign	A							E

	Ragistrar	dl= 4 - 11			Ce	rtifica	te of L	Death		2. Date of I	Reg. No).	,		
cian	Decedent's Name (First, Mid	die, Last)								Month	Da	,	Year	3. Time of	
lical	JOSSIE 4a. Facility Name (If not instituti	LAN		nher)		4h Cih	v Town or	Location o		ec. 2		005 . County o	of Death	7:09	<u> </u>
iner								LUCATION	Doam			•			
	5. Social Security Number	6. Sex			s. last birthday,		er 1 Year	If Under 2		8. Date of E	Birth	rince	9. Birthpl	rge's	r Fore
r	224-20-0766	1 🗆 N	u 2[x F	82	Yrs.	Months	Days	Hours	Min.		Day, Year)			ke, Va	
	Usual Residence of Decedent 10a. State 10b. Coun	h.		100.0	City, Town or L	acetian.						- 10			
7	Tod. State	• •		100. 0	nty, rown or L	ocation								0d. Inside Cit 1 🙀 Yes	
Director	Maryland Prince	e Geo	orge's	xO.	con Hil		ip Code				10a Ci	tizen of Wi	hat Count		
0	6249 Oxon Hill	Doad				101.2		20745			109.01	USA	nat court	, .	
Funerai	11. Marital Status			edent Ever in	U.S. 13.	Was Dec			gin? (Spe	offy Yes or I	No-	14. Race			
	1 ☐ Never Married 2 ☐ Ma	arried	Armed Fo 1 ☐ Yes If Yes, Giv						, Puerto F	lican, etc.)			, White, e	etc.	
d by	3 Widowed 4 Divorce	ed	Year or D	ates:		T Tes	2 ₹ No	Specify:				Specify:	B1ac	k	
Completed	15. Decede (Specify only high				16a. Dece (Give	edent's Us a kind of w	ual Occupa	ation during most I)	of workin	g	16b. K	and of Bus	iness/Ind	lustry	
l d	Elementary/Secondary (0-12		College (1	i-4or 5+)	life.		_				_				
	11th 17. Father's Name (First, Middle	e, Last)				Home	emake:		r's Name	(First, Mida		ivate			
o Be	James R. Fu	•								Covi		, ourname	′/		
P	19a. Informant's Name/Relation		e, Print)		19b. Mail	ing Addres	ss (Street a			Route Nun		or Town, S	State, Zip	Code)	
	Take II I seed													20745	
-	John H. Lane/s 20a. Method of Disposition			-	Place of Disp cemetery, cre	osition /Na	ame of			ate		ocation - C			
	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		moval from		ryland	,			2/30	/05	Lan	rel,	Mary	1 and	
i	21. Signature of Funeral Service			Pla						ome,]		ici,	Hary	Tand	
	16/2-6	2	- 1	2014								20001	i e		
	23a. nt1. Enter the disease, shock, or heart failure. Li	or complied	tions that c							Mach					
	0.10011, 01.1100111.101101		CAUSA ON A	aused the dea	ath. Do not en	nter the mo	de of dying	g, such as	cardiac or	Wash .	arrest,	20001		Approximate	e ween
	Immediate Cause (Final	st only wild	cause on e	aused the dea	ath. Do not en	nter the mo	Date of dying	g, such as a	cardiac or	wash.	arrest,	20001		Approximate Interval Betv Onset and D	ween
	Immediate Cause (Final disease or condition resulting in death)	a.	M	aused the deal ach line.	TRDIA	ter the mo	nde of dying	g, such as o	cardiac or	respiratory	arrest,	20001		Interval Bety	ween
	disease or condition resulting in death)	a	Due to (YOCA (or as a conse ABE	TRDIA equence of):	The mo	I Ave ode of dying INFO	g, such as of ARC	cardiac or	respiratory	arrest,	20001		Interval Bety	ween
	disease or condition resulting in death)	a	Due to (YOCK	TRDIA equence of):	HC ME	INF	g, such as of	cardiac or	respiratory	arrest,	20001		Interval Bety	ween
	disease or condition	a	Due to (OCABE	TRD // Equence of): TCS Equence of): LC D	HC ME	I Ave ode of dying INFO LLI IBITU	g, such as of	cardiac or TLO	respiratory	arrest,	20001		Interval Bety	ween
Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a	Due to (YOCA (or as a conse ABE	TRD // Equence of): TCS Equence of): LC D	HC ME	INF	g, such as of	cardiac or	respiratory	arrest,	20001		Interval Bety	ween
icai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a	Due to (OCABE	TRD // Equence of): TCS Equence of): LC D	HC ME	INF	g, such as of	cardiac or	respiratory	arrest,	20001		Interval Bety	ween
edicai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE:	d	Due to (Due to (for as a consecutive for a	ARD I A Proposed Art	HC ME	INF	g, such as of	cardiac or	respiratory	arrest,			Interval Betwonset and D	ween
edicai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or righry that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d	Due to (Due to (Due to (Due to (Due to (Due to (Due to (Due to (Due to (Due to (Due to (Due to (Due to (Due to ((or as a consection of pregion of pregion and at time of	ath. Do not en RD A equence of): CD equence of): anancy tal death 3 [ME	INF	g, such as of	cardiac or	respiratory	arrest,	23d. Date Mont	of deliver	Interval Betwonset and D	ween
edicai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	d	Due to (Due to (Due to (Due to (Due to (Due to (Due	(or as a consection of pregion of pregion and at time of	ath. Do not en RD A equence of): CD equence of): anancy tal death 3 [ME CCU DEctopic p	INF	g, such as of	cardiac or	respiratory	arrest,	23d. Date	of deliver	Interval Betwonset and D	ween
Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? t Yes 220 No	a	Due to (Due to	(or as a consection of pregrant at time of pown	ath. Do not en ARD A Aquence of): CC D Aquence of):	MECCL	INF	g, such as G	cardiac or	respiratory M	arrest,	23d. Date Mont	of deliver	Interval Betwonset and D	ween Death
by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or righry that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? t Yes 2 No 9 Unknown	a	Due to (Due to	(or as a consection of pregrant at time of pown	ath. Do not en ARD A Aquence of): CC D Aquence of):	MECCL	INF	g, such as G	cardiac or	RS 23e. Did	arrest,	23d. Date Mont	of deliver	Interval Betwonset and D	ween Death
by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or righry that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? t Yes 2 No 9 Unknown	a	Due to (Due to	(or as a consection of pregrant at time of pown	ath. Do not en ARD A Aquence of): CC D Aquence of):	MECCL	INF	g, such as G	cardiac or	23e. Dic 1[d tobacco	23d. Date Mont	of deliver	TY Day Y e cause of deably 4 XIU	ween Death
ompleted by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or righry that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? t Yes 2 No 9 Unknown	a	Due to (Due to	(or as a consection of pregrant at time of pown	ath. Do not en ARD A Aquence of): CC D Aquence of):	MECCL	INF	g, such as G	cardiac or	23e. Did	d tobacco Yes 2 as an topsy	23d. Date Mont use control No 3	of deliver	Ty Day Y e cause of deably 4 XU esy findings a	ween Death
e Completed by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? t	a. b. c. d. 23c	Due to (Due to	(or as a consection of pregrant at time of pown	ath. Do not en ARD A Aquence of): CC D Aquence of):	MECCL	INF	ARC TUS US V	LCE	23e. Did	d tobacco Yes 2 as an lopsy drormed?	23d. Date Mont use control No 3	of deliver	Ty Day Y e cause of deably 4 XU esy findings a	ween Oeath 'ear
Completed by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condi	b	Due to (Due to	(or as a consection of pregrant at time of pown)	ath. Do not en ARD A Aquence of): CC D Aquence of):	MECCU Bectopic Other (s	INFO	Q, such as of ARC IUS US US 4.5 US 4.6 Place	acardiac or	23e. Did	d tobacco Yes 2 as an topsy formed? 250 No	23d. Date Mont use contrib	of deliver	Ty Day Pably 4 XIU Sy findings a pletion of ca	ween Oeath 'ear
To Be Completed by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. b. c. d. 23c tions control	Due to (Due to	for as a consection of pregrant at time of own	ath. Do not en A D A A popular of): C D A popular of):	Ectopic Other (s	pregnancy specify)cause give	Q, such as of ARC US US US unin Part I.	of Death	23e. Did 24a. Wall per 1 Yes Check only	d tobacco Yes 2 as an topsy rformed? 250 No	23d. Date Mont use contribuse contribuse contribuse contribuse contribuse and con	of deliver th bute to the g Proba ere autopior to com sath? Yes	Ty Day Pably 4 XIU Sy findings a pletion of ca	ween Oeath 'ear
To Be Completed by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? t	a. b. c. d. 23cd tions control ding stigation	Due to (Due to	for as a consection of pregration of pregrat	ath. Do not en A D A Equence of): Dequence of): A D A Equence of): A D A Equen	Ectopic Other (s	pregnancy specify) cause give	Q, such as of ARC US US US unin Part I.	of Death	23e. Did 24a. Wh au pe 1 Yes Check only	d tobacco Yes 2 as an topsy rformed? 250 No	23d. Date Mont use contribuse contribuse contribuse contribuse contribuse and con	of deliver th bute to the g Proba ere autopior to com sath? Yes	Ty Day Pably 4 XIU Sy findings a pletion of ca	ween Oeath 'ear
To Be Completed by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? t	a. b. c. d. 23cd tions control ding stigation	Due to (Due to	come of pregriith 2 Fe ant at time of own	ath. Do not en A D A Equence of): C D Equence of): A D Equence	Ectopic p Other (s	pregnancy specify) cause give	Q, such as (2)	of Death	23e. Dice 24a. What was per 1 Yes Check only e 5 Re Red. Describ	d tobacco	23d. Date Mont use contribuse contribuse contribuse contribuse contribuse and Number of Number o	of deliver	Ty Day Pably 4 XIU Sy findings a pletion of ca	ween Death 'ear eath? inknov availatause o
Certification; To Be Completed by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. b. c. d. 23cd tions control tions control tions distinguished tiling	Due to (Due to	(or as a consection of pregrate of pregrate of pregrate of pregrate of pregrate of pregrate of pown seath but not respectively.) of Injury At Ing, etc. (Spection of Injury - At Injury -	ath. Do not en A D A Equence of): Dequence of)	Ectopic Other (s	pregnancy specify)	g, such as of ARC US US US 4 An in Part I.	of Death rising Home	23e. Did 24a. Wt au pe 1 Yes Check onl e 5 Re 8d. Describ City or 7	d tobacco Yes 2 as an topsy formed? 2 No rone sidence e how inju	23d. Date Mont use contributed in No. 3 24b. W. pringer of the normal of the normal of Number (a) 1 (1) (1) (1) (1) (1) (1) (1) (1) (1)	of deliver the substitute to the B Proba ere autoprior to com- path? T (Specify, d	Ty Day Posy findings a poletion of ca	ween Death Year Beath? Hinknov availat ause o
Certification; To Be Completed by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? t	tions control d d ot be mined	Due to (Due to (Due to (Due to (Due to (D	(or as a consection of Injury At Ing., etc. (Special Special S	ath. Do not en PRD A Equence of): LC D Equence of): Anancy tal death of the	Ectopic p Other (s	pregnancy specify) cause give	g, such as of ARC TUS US us in Part I.	of Death rising Home	23e. Did 24a. Wh au pe 1 Yes Check on e 5 Re Bd. Describ	d tobacco Yes 2 as an lopsy formed? 250 No	23d. Date Mont use contrib No 3 24b. Wypride 1 [6] Other ry occurred of Number 9)	of deliver the bute to the same autoprior to compart? If (Specify, deliver)	Py Day Y e cause of de ably 4 🔊 Upsy findings a apletion of ca	ween Death Year Beath? Both Both
edical Certification; To Be Completed by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? t	tions control all Hosting tiligation d not be mined	Due to (Due to (Due to (Due to (Due to (D	come of pregriinth 2 Fer ant at time of own npatient 2 for Injury At Ing., etc. (Special accessed by Special Accessed by Spec	ath. Do not en A D A Equence of): Dequence of)	Ectopic potential of the courrect of the occurrent vestigation of the courrect of the occurrent oc	pregnancy specify) cause give	Q, such as if	of Death rising Home	23e. Did 24a. Wh au pe 1 Yes Check on e 5 Re Bd. Describ	d tobacco Yes 2 as an topsy dormed? 250 No one (Street ar own, State the cause(s e, date and	23d. Date Mont use contrib No 3 24b. Wingride 1 [6 Other No occurred	of deliver the bute to comport to compath? If (Specify, deliver or Rural and due to but to the bute to the bute to the bute to the bute to but	Py Day Y e cause of de lably 4 SU osy findings a pletion of ca 2 No Route Numb the cause(s)	ween Death Year Beath? Both Both
Certification; To Be Completed by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? t	tions control all Hosting tiligation d not be mined	Due to (Due to (Due to (Due to (Due to (D	(or as a consection of Injury At Ing., etc. (Special Special S	ath. Do not en PRD A Equence of): LC D Equence of): Anancy tal death of the	Ectopic potential of the courrect of the occurrent vestigation of the courrect of the occurrent oc	pregnancy specify) cause give	Q, such as if	of Death rising Home	23e. Did 24a. Wh au pe 1 Yes Check on e 5 Re Bd. Describ	d tobacco Yes 2 as an topsy formed? 250 No vone e how inju (Street ar own, State e cause(s e, date and	23d. Date Mont was contributed from the Mont of Mont o	of deliver the bute to compare the compare to compare the comparent of the comparent of the bute to th	Py Day Y Day Y Day Holdings and pletion of call No Provided Number 1997 (1997) The cause(s) Day, Year)	ween Death 'eath 'eath? eath? eath? bear eath?
edical Certification; To Be Completed by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? t	tions control all Hosting Physical Examines	Due to (Due to (Due to (Due to (Due to (Due to (Due to (Due t	(or as a consector of pregrint 2 February 1	ath. Do not en A D A A popular of): A pop	Ectopic Other (s	pregnancy specify) cause give	Q, such as if	of Death rising Home	23e. Did 24a. Wh au pe 1 Yes Check on e 5 Re Bd. Describ	d tobacco Yes 2 as an topsy formed? 250 No vone e how inju (Street ar own, State e cause(s e, date and	23d. Date Mont was contributed from the Mont of Mont o	of deliver the bute to compare the compare to compare the comparent of the comparent of the bute to th	Py Day Y Day Y Day Holdings and pletion of call No Provided Number 1997 (1997) The cause(s) Day, Year)	eath? eath? eath? eath? bear
edical Certification; To Be Completed by Physician/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? t	tions control all Hosting Physical Examines	Due to (Due to (Due to (Due to (Due to (Due to (Due to (Due t	(or as a consector of pregrint 2 February 1	ath. Do not en A D A A popular of): A pop	Ectopic Other (s	pregnancy specify) cause give	Q, such as if	of Death rising Home	23e. Did 24a. Wh au pe 1 Yes Check on e 5 Re Bd. Describ	d tobacco Yes 2 as an topsy formed? 250 No vone e how inju (Street ar own, State e cause(s e, date and	23d. Date Mont was contributed from the Mont of Mont o	of deliver the bute to compare the compare to compare the comparent of the comparent of the bute to th	Py Day Y e cause of de lably 4 SU osy findings a pletion of ca 2 No Route Numb the cause(s)	eath?

0-08811	-	1.				Ith and Montal Us		
lles Ley	polo	T State	State of M		ertificate of De	Ith and Mental Hy	2005	43541
		Registrar 1. Decedent's Name (First, Middle,	(act)	CE	erinicate of De	2. Date of Di	Reg.(No.)	
Phys	ician					Month	Day Year	3. Time of Death
1	dical	MILES KARSCH		1	4b. City, Town, or Loc	December December	er 28, 2005 4c. County of Dea	3:30 P M
Exar	niner	4a. Facility Name (If not institution,			40. City, Town, or Eco	anon or Death		un
		28026 Oakland C		ge (In yrs. last birthday	Easton If Under 1 Year If U	Under 24 Hrs. 8. Date of Bi	Talbot	tholace (State or Foreign
Funer Direct		562-01-1044	6. Sex 7. Ag	93 Yrs.	Months Days H	ours Min. 8. Date of Bi	ay, Year) C 12, 1912 N	rthplace (State or Foreign ountry) EBRASKA
		Usual Residence of Decedent			, 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	, , , , , , , , , , , , , , , , , , , ,		B TUX DIVIX
nylan how		10a. State 10b. County	DOM:	10c. City, Town or I				10d. Inside City Limits
Ma Ma	cto	MD TAL	BOL	EA	STON			1 ☐ Yes ¾ ☐ No
th th or 28	- Ire	10e. Street and Number			10f. Zip Code		10g. Citizen of What C	ountry?
1215-0036 within 72 hours atter death with the Maryland and. ana. Then "netural", or items 23e or 28a-f ehow Medical Exacilities Internative modified at	Funeral Director	28026 OAKLAND	CIRCLE			1601		SA
r daz	- P	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	 Was Decedent of Hispar If Yes, specify Cuban, M 	nic Origin? (Specify Yes or Ni exican, Puerto Rican, etc.)	14. Race - Am Black, Whi	
36 safte	by F	1 ☐ Never Married 2 🛣 Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No	1 ☐ Yes 2 🕱 No Sp	oecity:	Specify:	WHITE
Maryland 21215-0036 To 2 should be filed within 72 hours aft th and Mantal Hygiana. Z7 le marked other then "natural", or reaumatic event, the Medical Exercit	De De	15. Decedent's	Year or Dates:	162 Dec	edent's Usual Occupation		16h Kind of Business	Maduata
15. n 72	ete	(Specify only highest	grade completed)	(Giv	re kind of work done durin DO NOT use retired)	g most of working	16b. Kind of Business	sindustry
the state of the s	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	ILOT		COMMERCIAL	AVTATION
Hyg ether	Ö	17. Father's Name (First, Middle, L	ast)			Mother's Name (First, Middle		IX IIIII
and based of the second of the	To Be	CHARLES L. LEY	POLDT			ANNA KARSCH		
Should M		19a. Informant's Name/Relationshi	p (Type, Print)	19b. Mai	ling Address (Street and I	Number or Rural Route Numb	er, City or Town, State,	Zip Code)
Market a 27 le		MELINDA L. LAZA	RUS/DAUGHTE	R 105	MIXVILLE R	OAD, CHESHIRE	, CT	
s 1 e		20a. Method of Disposition		20b. Place of Disp	position (Name of ematory or other place)	Date	20c. Location - City or	Town, State
Baltimore, Maryland 21215-0036 permit. Pagas 1 and 2 should be filed within 72 hours atter death with the Marylan Deportment of Health and Mantal Hygians. Important: If them 271 is marked other then "natural; or thems 23e or 28e-f show eny injury or other traumatic event, the Medical Exertine mast to rediffed at		1 ☐ Burial 2 MCremation 3 4 ☐ Donation 5 ☐ Other (Sp.		CHESAPEA	KE CREMATIO	N CTR 12/31/20	05 STEVENS	VILLE, MARYLA
mit.	Ŕ	21. Signature of Funeral Service L				FENBEIN & NEW		
W ggr	ä	Joseph m. O	strowski CF			SON ST EASTON.		HOME FA
		23a. Part1. Enter the disease, or c shock, or heart failure. List o	complications that cause	d the death. Do not er				Approximate Interval Between
Physicia	an.	Immediate Cause (Final	O COL	1110.				Onset and Death
/Medic		disease or condition resulting in death)	a. Due to (or as	a (consequence of):				
Examin	er							
	je j	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):				
cutad nd ransii	Examiner	that initiated events	С.					
60, be axecutad ician end burial-transit	EX	resulting in death) Last	Due to (or as	a consequence of):				
a ta	cal		d					
fiftical right as the	Physician/Med	IF FEMALE:						
Box aath cer attandin for usa	an/I	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		□Ectopic pregnancy		23d. Date of de	
.O. E tha daa by the at	SICI	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at 9□Unknown		Other (specify)		Month	Day Year
P.C hat the d by t	Phy	9 Unknown						
I Records, P.O. Box 68 The law requires that the death certifica tate has been signed by the attending phoage 2 should be detached for use as it.	6	Part II. Other significant condition	is contributing to death b	out not resulting in the	underlying cause given in		tobacco use contribute to	
cord v requir been si	Completed					1 1 1 1	Yes 2.2(No 3 □ P	robably 4 Unknown
Vital Records, sician: Tha law requires to cartificate has been signe rector, page 2 should ba.	ple					24a. Was	an 24b. Were a	utopsy findings available completion of cause of
Tha Tha atah page	ő					perf	ormed? death?	_
/ita cian: artific actor,	Be	25. Was case referred to medical examiner?				Place of Death (Check only	one)	
of Vita Physician: r this cartific	2	1 √xes 2 □ No		ent 2 ☐ ER/Outpatie		☐ Nursing Home 5☐ Res	dence 6 🔀 Other (Spe	en Scene
Ing P	on:	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Inju (Month, Da	28b. Time Injury	Work?	5 K.	how injury occurred	cto Self
Vision Attending r death. ector: After	cat	2 Accident investiga 3 Suicide 6 Could no	- CX CX 0	3.3	OρM 1□Yes			
Division I or Attending after death. Director: After	Certification:	4 Homicide determin	and 286. Place of in	jury - At home, farm, s tc. <i>(Specify)</i>	1	281. Location (Street and Number or R wn, State	
pital urs a aral [ပိ	20a Continu	Dhadala Taba		sidence	- Cas	ton Mo	
Division of Vital Re To the Hospital or Attending Physician: Tha I within 24 hours after death. To the Funaral Director: After this cartificate he complately filled in by the funeral director, page	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	xaminer: On the basis o	of examination and/or i	ath occurred at the time, d investigation, in my opinio	ate and place, and due to the n, death occurred at the time,	date and place, and du-	s stated. e to the cause(s)
To the within 2 To the complat	Med	29b. Signature and title of certifier	and manner st	aidu.	29c. License nur	mber	29d. Date signed (Mont	th. Dav. Yearl
S T TOO		10-0		-Qna				
(i		Follow	unu	TOUR STATE OF THE PARTY OF THE	OCME		December 29	9, 2005
(6)		30 Name and address of person w	1 / 11 1 1			imore, Marylan	d 21201	
	State	31. Date filed (Month, Day, Year)		rar's Signature	Daria	more, raryran	<u>u 21201</u>	
	istrar		006	y B A				

	an	Decedent's Name (First, Middle, L CULT D. E.V.	,			•	Date of Dea Month	Day Ye	1211-12
/Medic	cal	SHIRLEY 4a. Facility Name (If not institution, g	MARIE	MC	CGUIGAN		December		
xamir	ier	DOCTORS COMMUNIT			LANHA	wn, or Location of Dea M	ain	4c. County of E	
neral			Sex 7. Age (In yrs	s. last birthday)	If Under 1	Year If Under 24 Hr			Birthplace (State or For Country)
ector		577-50-3731 Usual Residence of Decedent	1□ M 2 🛣 68	Yrs.		Days Hours Mir	JUNE 17	, 1937 WA	SHINGTON, I
s or 289-1 show	Director	MD 10b. County Prince	_	City, Town or Lo	LTON				10d. Inside City Lir 1∭Yes 2☐
3a or 2	i Dir	10e. Street and Number 5337 85th AVENUE	#12		10f. Zip Co			10g. Citizen ol What U.S.A.	t Country?
or Items 2	y Funerai	11/4 Marital Status 1 Never Married 2 Married	If Yes, Give	1	Was Deceden I Yes, specify	t of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No- irto Rican, etc.)	14. Race - A	merican Indian, Vhite, etc.
and Ex	ed by	3 X Widowed 4 ☐ Divorced 15. Decedent's I	Year or Dates:		dent's Usual C			16b. Kind of Busine	
nan n	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)	(Give	kind of work of DO NOT use i	done during most of w retired)	orking	TOD. KING OF DUSINE	ssamuustiy
ant,	CO	12th 17. Father's Name (First, Middle, Las	st)	HOUSE	KEEPIN		ame (First, Middle,	PRIVATE Maiden Sumame)	
arked o	To Be	HOWARD WILLIAM J				LILLIAN		mason Samano,	
r tem 27 is marked other than " ir other traumatic event, ILE Me		19a. Informant's Name/Relationship GLORIA J. COOK/S	(Type, Print) ISTER			treet and Number or F			e, Zip Code)
r item or othe		20a. Method of Disposition 1 □ Burial 2 X Cremation 3	Removal from State	Place of Dispos	natory or othe	r place)		20c. Location - City	
jury		4 □ Donation 5 □ Other (Spec	rify) Ri			tory 12-			
enyinjury or or or on one one or		21. Signature of Funeral Service Lice	Lall			Address of Facility J			HOME
niner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Dissemineta Due to (or as a conse b. Cardio - Pur Due to (or as a conse	luonice of):	y Anis	1.			
nysician and he burial-transit	Icai	that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):					
by the attending physician and ached for use as the burial-transit	Icai	that initiated events		nancy tal death 3	Ectopic pregr Other (specia			23d. Date of Month	delivery Day Year
be detached for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	Due to (or as a consect of d. 23c. If yes, outcome of pregration of the consect	nancy tal death 3 [] death 5 []	Other (special	(y)		Month	Day Year
S should be detached for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as a consect of d. 23c. If yes, outcome of pregration of the consect	nancy tal death 3 [] death 5 []	Other (special	(y)	1 Yes	Month bacco use contribute es 2 No 3 in 24b. Were sys prior ged?	Day Year to the cause of death Probably 4 Minknot autopsy findings availate to completion of cause
S should be detached for use as	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions	Due to (or as a conse d. 23c. If yes, outcome of pregr 1	nancy tal death 3 [] death 5 []	Other (special	e given in Part I. 26. Place of De	1 Your 24a. Was a autops perform 1 Yes :	Month bacco use contribute es 2 No 3 in 24b. Were ey prior death 22 No 1 Y	Day Year b to the cause of death? Probably 4 Minknot autopsy findings availate completion of cause? es 2 No
S should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No	Due to (or as a consect of d. 23c. If yes, outcome of pregration of the control	nancy tal death 3 death 5 sulting in the un	Other (special derlying caus	26. Place of De	1 Yu 24a. Was a autops perform 1 Yes seath Check only on thome 5 Reside	Month bacco use contribute es 2 No 3 In in 24b. Were esy prior death 22No 1 Y ence 6 Other (S	Day Year le to the cause of death Probably 4 Minknot autopsy findings availate completion of cause 'es 2 \square\$ No
S should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending investigation	Due to (or as a consect of d. 23c. If yes, outcome of pregrit Live birth 2 Fel 4 Pregnant at time of 9 Unknown contributing to death but not research. Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	nancy tal death 3 death 5 deat	Other (special deriving caused as the special deriving deriving caused as the special derivin	26. Place of De Other: Wureing Injury at Work? 1 Yes 2 \(\) No	1 Yu 24a. Was a autops perform 1 Yes seath Check only on thome 5 Reside	Month bacco use contribute es 2 No 3 in 24b. Were ey prior death 22 No 1 Y	Day Year le to the cause of death Probably 4 Minknot autopsy findings availate completion of cause 'es 2 \square\$ No
S should be detached for use as	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigatic determined	Due to (or as a consection of the consection of	sulting in the un ER/Outpatient 28b. Time of Injury	other (special deriving caused as 28c. M	26. Place of De Other: Aureing Injury at Work? 1 Yes 2 No	24a. Was a autops perform 1 Yes seath Check only on Home 5 Reside 28d. Describe he 28f. Location (Si City or Town	Month bacco use contribute es 2 No 3 In contribute es 2 In contribute es 2 No 3 In contribute es 2 In contribute es	Day Year The to the cause of death? Probably 4 Minknot autopsy findings availate to completion of cause? Probably 4 Minknot autopsy findings availate completion of cause? Pec 2 No Pecify)
S should be detached for use as	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigating investigating investigating investigating the process of	Due to (or as a consect of the conse	Description of the understand the un	Other (special deriving caused as the special at th	26. Place of De Other: Wursing Injury at Work? 1 Yes 2 No	24a. Was a autops perform 1 yes seath Check only on Home 5 Reside 28d. Describe house 28f. Location (Single City or Town	Month bacco use contribute es 2 No 3 In 24b. Were prior death 22 No 1 Y ence 6 Other (S ow injury occurred freet and Number or 1, State)	Day Year Probably 4 Minknot autopsy findings availate to completion of cause 1? Pecify) Pural Route Number,
2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consect of the proof of the	Description of the understand the un	Other (special deriving caused at the estigation, in	26. Place of De Other: Wursing Injury at Work? 1 Yes 2 No	24a. Was a autops perform 1 yes seath Check only on Home 5 Reside 28d. Describe how 28f. Location (Si City or Town	Month bacco use contribute es 2 No 3 In 24b. Were prior death 22 No 1 Y ence 6 Other (S ow injury occurred freet and Number or 1, State)	Day Year a to the cause of death? Probably 4 Minknot completion of cause of the cause of death? Probably 4 No Cause of the cause of
should be detached for use as	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Anner of Death 1 Anner of Death 3 Suicide 6 Could not determined 1 Check only one)	Due to (or as a consect of d. 23c. If yes, outcome of pregration of the pregnant at time of the pregn	sulting in the un ER/Outpatient 28b. Time of Injury nome, farm, streetify) towledge, death ation and/or inventor and/or in	occurred at testigation, in	26. Place of De Other: Wureing Injury at Work? 1 Yes 2 No flice the time, date and place my opinion, death occ	24a. Was a autops perform 1 yes seath Check only on Home 5 Reside 28d. Describe how 28f. Location (Si City or Town	Month bacco use contribute es 2 No 3 In 24b. Were prior death 22 No 1 Y ence 6 Other (S ow injury occurred bacco use contribute freet and Number or 7, State) ause(s) and manner ate and place, and of	Day Year a to the cause of death' Probably 4 Minknot autopsy findings availate to completion of cause Proceedings of the course of the cause o

Moquigan, Shirley

			Please	State of Ma				•		
			1 - For State	State of Ma	ryland / Depa	artment of Fi rtificate of D			CUUS	43543
			Registrar 1. Decedent's Name (First, Middle, La.	st)	Ce.	rincale of L	Jeani	2. Date of Dea	Reg. No.	3. Time of Death
	Physici		Joseph Duncan	McLellan				Month	Day Year 26, 2005	5:30 P M
1	/Medic Examir		4a. Fecility Name (If not institution, give			4b. City, Town, or	Location of Death	Decembe	4c. County of Death	
	LXaiiii	ici	Saint Thomas More			Hyattsvi	11e		Prince Geo	orge's
	Funeral		5. Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day		place (State or Foreign intry)
	Director		017 22 0701	MM 2□F	76 Yrs.	24,0		March 2	7, 1929 Mass	sachusetts
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryl f ehc	to			Washingto	m. DC				1∰Yes 2 No
	7 286	Director	10e. Street and Number		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10f. Zip Code			10g. Citizen of What Cou	ntry?
	th with	al D	1224 Fairmont Str	eet N.W.		20009			U.S.A.	
	ems ems	by Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp.	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	or it	y Ft	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 N If Yes, Give	0	1 Yes 2 No	Specify:		Canaltu	ite
Ö	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f ehow fa Madical Examiliar rust be rediffed at	q pe	15. Decedent's Ed	Year or Dates:	162 Dece	dent's Usual Occupa	tion		16b. Kind of Business/Ir	
5	in 72	plet	(Specify only highest gra	ade completed)	(Give	kind of work done d DO NOT use retired)	uring most of work	ing	Top. Nata of Dashidsan	ioustry
21215-0036	d with giene grene	Completed	Elementary/Secondary (0-12)	College (1-4or 5- 5+		Critic			Washington	Post
pu	2 should be filed within and Mental Hygiene. Is marked other than aumetic avant, Ire Me	Bec	17. Father's Name (First, Middle, Last)	!			18. Mother's Name	e (First, Middle,	Maiden Surname)	
yla	should the not Ment marked umetic s	10	Malcolm McLellan				Elsie Ma	7		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. itam 27 is marked other than "natural", or items 23a or 28e-f ehow other traumetic event, if e Madical Examinar has be ruffled at		19a. Informant's Name/Relationship (Patricia C. McLel			-			r, City or Town, State, Zi	-
	permit. Pages 1 and 2 Department of Health s Important: If itam 27 Is any injury or othar tra once.		20a. Method of Disposition	Tan - wile	20b. Place of Dispo	osition (Name of		Date Was	hington, DC	
Baltimore,	ages int of t: If it		1 Burial 2 Cremation 3 C `4 Donation 5 Other (Specif			matory or other place e Cemetery		/2005		
Ħ	artme ortan injur		21. Signature of Funeral Service Licer	•					Beltsville, meral Home,	
B	permi Depar Impor any ir		Valeni / text	5 701	L				attsville,	
	100		23a. Part1. Enter the disease, of com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not en					Approximate Interval Between
V.	Physician		Immediate Cause (Final disease or condition	Autor		enotre C	andio	lascola	- Disarse	Onset and Death
	/Medical		resulting in death)	oue to (or as a	consequence of):	4.0. 0	(CL	0,4-0.00	S. G. G.	1 3/15
	Examiner	_	Sequentially list conditions,	b						
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
•	be executed sician and burial-transit	Exan	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
760,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	calE	l	d						
68	tificat ng phy as th									
Вох	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy 2 Detail death 3	DEctopic pregnancy			23d. Date of deliv	
	e dea the at ned fo	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at t 9☐ Unknown	time of death 5	Other (specify)			Month	Day Year
P.O.	The law requires that the death ate has been signed by the atter page 2 should be detached for u	Phy	Part II. Other significant conditions of	contributing to death bu	t not resulting in the u	ınderiving cause give	n in Part I	23e. Did to	bacco use contribute to	the cause of death?
ds,	signe signe	d by	Rud Stape 1	renad D	4case	,				bably 4 □Unknown
cor	w requ	lete	D'al-a Des	Madra	0 44	penten	67.04	24a. Was a	an 24h Were aut	onsy findings available
of Vital Records,	sician: The law certificate has b irector, page 2 s	Completed by	Charles		1	Ben n	7101	autop perfor	med2 death?	opsy findings available ompletion of cause of
ta		Be C	25. Was case reterred to medical	schal O	(clus,)	Λ1	26. Place of Deatl		2☑No 1☐Yes	2 No
>	Physician: r this certificatal director.	ToE	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 ER/Outpatie	nt 3□ DOA Othe	r. 4 Nursing Ho	me 5 Resid	ence 6 Other (Speci	fy)
ОП	ng Pl		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Work	at ?	28d. Describe h	ow injury occurred	
Sio	Attending or death. actor: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not b				′es 2 □No	00(1) (0		
Division	or At after d Diraci in by	Certification:	4 Homicide determined		ry - At home, farm, st . (Specify)	reet, factory, office		281. Location (S City or Tow	treet and Number or Rur n, State)	al Route Number,
_	Hospital Pours S Funerel		29a. Certifier 1 Certifying Ph	vsician: To the best of	f my knowledge, deat	h occurred at the time	e date and place.	and due to the o	ause(s) and manner as	stated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical Exar	miner: On the basis of and manner state	examination and/or in	vestigation, in my op	inion, death occur	ed at the time, o	late and place, and due t	to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	00	0	29c. License			29d. Date signed (Month,	
			Phullen	Veure	4	5) 0	1852	- 1) ECEMBER	27,2005
R	(5)		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type,	Print)	Do	4 7	DECEMBER	17-78
1	Sta	ato.	31. Date filed (Month, Day, Year)	2. Registra	r's Signature	rusens	الماليات	ryal	120, ICC/9	w - w - w
*	Regist		DEC 3 0 200		1 has	de la				

			1 - Stete CCHD BB Registrar AMEND#26 PF	State of Ma							ental Hy	giene		5	43544
	-		Oecedent's Name (First, Middle, Last)		4,2010			-			2. Date of De			Year	3. Time of Oeath
	Physicia /Medic		FRANCIS CHARLES MA	DDOX, SR.							DECEMB	ER 2	5, 20	005	3:35P M
	Examin	er	4a. Fecility Name (If not institution, give	street and number)					Location of	of Death		17/5	County o		
	Funeral	G I	GENESIS ELDERCARE 5. Social Security Number 6. Sec	7. Age	(In yrs. las	t birthday)		r 1 Year	If Under		8. Date of Bir	rth	HARLI	9. Birthp	lace (State or Foreign
	Director		578-36-6342	M 2□F	78	Yrs.	Months	Oays	Hours	Min.	(Month, Da			MAR	
	and w		Usuel Residence of Decedent 10a. State 10b. County		10c. City, 1	Town or Lo	cation								0d. Inside City Limits
	Marylan f ehow	lor	MD CHARLES			JEMOY									1 Yes 2 No
	r 28a	irec	10e. Street and Number				10f. Zi	p Code				10g. Cit	tizen of Wi	hat Cour	itry?
	within 72 hours after deeth with the Maryland sne. Than "natural", or liems 23e or 28e-f ehow na Medical Examinar must be molified at	Funeral Director	4160 SAMUEL PLACE	 			20	0662				UNI	TED S	STAT	ES
	er dee	nue	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Vas Dece f Yes, spe	dent of Hi orfy Cuba	spanic Ori n, Mexicar	gin? (Spec n, Puerto R	ify Yes or No lican, etc.)	0-	14. Race Black	 Americ White, 	
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ▼ No If Yes, Give X Year or Dates:	0	1	□ Yes	2 X No	Specify:				Specify:	BI.	ACK
21215-0036	2 hou	ted	15. Decedent's Edu (Specify only highest grad			16a. Deced	lent's Usu	al Occupa	ation	t of workin	0	16b. K	and of Bus		
21	ithin 7 ner Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)	life. L	OO NOT	ise retired)	(or Morking	y	CON	ompre.		17
2	filed w Hygier other th		17. Father's Name (First, Middle, Last)		;	TRUCK	DKT	VEK	18. Mothe	er's Name	(First, Middle	-	STRUC		N
Maryland	ges 1 and 2 should be filed within 72 hours after deeth with the Maryla to f Health and Martal Hygiens are treated to the Maryla II tiem 27 is marked other than "natural", or liems 23a or 28a-1 show if II tiem 27 is marked other than "natural", or liems 23a or 28a-1 show or other treumstite event, the Mardical Examinar must be codified at	To Be	WILLIAM MADDOX, SR	•							IE ASH				
Man	th and the mark treams		19a. Informant's Name/Relationship (Ty ANN POSEY/DAUGHTER				•				Route Numb				•
ē,	s 1 and f Health Item 27 other tr		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Na	me of	Ţ	Da	<u> </u>		ocation - C		
E O	Pages nent of ant: If It ary or o		Marial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State		CHARL			-	DEC.	31, 200	5 G1	LYMON	Т, М	I D
Baltimore,	permit. Pages 1 and 2 Depertment of Health a Important: if Item 27 le eny injury or other tre once.		21. Signature of Funeral Service Vicens LYDIA C. THORN	TON JOHNS	ONCO	- T	Name a HORN 139 L	nd Addres FON F VINGS	s of Facilit	tv	ME P. A DIAN HE				
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused the cause on each line	the death. e.	Do not ente	er the mo	de of dying	g, such as	cardiac or	respiratory a	rrest,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CANC	ren	M	0	101	\vee						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequer	nce of):	\								
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	Due to (or as a	consequer	nce of):	1								
	cate be executed bhysicien and the burial-transit	Examiner		s											
8760,	be exicien a	E E	resulting in death, tast	Oue to (or as a	i consequer	nce ot):									
687	physics the	edical		d											
Box (eath certific ettending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of									23d. Oate	of delive	ory
	e death he ette	Physician/Me	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown			Other (s	pecify)					Mont	th	Day Year
P.0	that the de ned by the e detached f		9 ☐ Unknown Part II. Other significant conditions co.	ntributing to death but	t not resulti	na in the ur	nderlyina	cause dive	en in Part I		23e. Did	tobacco	use contrib	oute lo th	ne cause of death?
rds,	quires tha n signed uld be de(ed by									10	Yes 2	□No 3	3 🗌 Prob	ably 4 Unknown
Records,	The law requires that the death certificate be executed ste has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Completed									24a. Was	psy	24b. W	ere auto	psy findings available mpletion of cause of
<u>=</u>	ician: The lav certificate has rector, page 2	Con									perfe 1 Yes	2/Z/No	de	ath?	2 No
of Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	fospital:				Othe	25		(Check only	-	- 00		
o	Phys or this oral di	٥ :	1 ☐ Yes 2 € No	1 ☐ Inpatien 28a. Date of Injury (Month, Day		NOutpatien 8b. Time of		28c. Injury	at		e Res 8d. Describe				y)
ion	Attending or death. ector: After by the fune	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	м	Work	∢? Yes 2 🗌	No					
Division	or Atteater designation of Atteater designation of the Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc.	ry - At hom . (Specify)	e, farm, str	eet, facto	ry, office		2	8f. Location (City or To	Street ar	nd Number e)	r or Rura	l Route Number,
_	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		(Check only 2 Medical Exemi	sicien: To the best of ner: On the basis of	examination	edge, death	occurre	at the tim	ne, date an	nd place, a	nd due to the	cause(s) and man	ner as si	tated. the cause(s)
	thin 24 the F	Medical	29b. Signature and title of certifier	and manner stat	ted.			c. License							Day, Year)
	vit To To		Maril	1/2/	1	M	1	110	00	,20	9		17	1-7	0105
			30 Name and address of person who co	ompleted cause of de	eath (Item 2	3a) (Type.	P(int)	1 L			('		12	10	0100
_	BBI		(GRODEN)	JWE	ECC	5-)1	MA	M	AL	DOR	· F.	MI	X.	20003
	Sta	ite ar	31. Date filed (Month, Day, Year) DEC 2 9 20	32. Registra	_	e L									

			1 - For State Registrar	State of Ma		partment of F ertificate of		nd Ment	tal Hygier Reg. I	ZUU	5 4	3545
	Physici /Medio		Decedent's Name (First, Middle, Las MARY A		IENS				ate of Death fonth EC. 25	2005		ime of Death OOAM M
	Examir		4a. Facility Name (If not institution, give LAUREL REGIO)		ITAL	4b. City, Town, o		Death		4c. County of D		
	Funeral Director		5. Social Security Number 6. Security Number 161 38 0730	ex 7. Age □ M 2 x F	e (In yrs. last birthda 61 Yrs	Months Days	If Under 24 Hours	Hrs. 8. D Min. (A	ate of Birth Month, Day, Yea E 28 1	944	Birthplace (Country) PA.	State or Foreign
	Maryland 8-1 chow	stor	Usual Residence of Decedent 10a. State 10b. County P.G.		10c. City, Town or LAUI						L.	side City Limits ¥es 2 □ No
	with the	Director	10e. Street and Number 9327 RIDINGS W	7 N V		10f. Zip Code	723		10g.	Citizen of What	Country?	
3036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23e or 28e-f ehow marked other than "natural", or items 23e or 28e-f ehow maric event, its Marylal Examinations to be notified at	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	Ever in U.S. 1	3. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No		n? (Specify) Puerto Ricar	Yes or No- n, etc.)	14. Race - A Black, W Specify:BI	hite, etc.	ian,
Maryland 21215-0036	I within 72 h iene. r than "natu	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(G	cedent's Usual Occup ve kind of work done o DO NOT use retired HOMEMAK	during most o d)	of working	16b.	Kind of Busine		
/land ?	should be filed nd Mental Hyg marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) RAYMOND STAR	RKS	,				at, Middle, Maid ALLEN			
ā	E E E		19a. Informant's Name/Relationship (7 TRACY CARTHORN		1.0	7 RIDING)
altimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other tre		20a. Method of Disposition 1 National 2 Cremation 3 Characteristics of the Company of the Compa		20b. Place of Dis	position (Name of rematory or other place LL CEMET	ee)	Date 2/30/	20c.	Location - City	or Town, Si	
Balti	permit. Departm Importe eny inju	ļ	21. Signature of Funeral Service Licen	See		22. Name and Addres 3435 14	ss of Facility	WATSO	N F. I			
	Pnysician		23a. Part 1. Inter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition		I the death. Do not ne.	enter the mode of dyin	g, such as ca	rdiac or resp	oiratory arrest,		Inten	oximate val Between if and Death DAYS
9	/Medical Examiner		resulting in death)		a consequence of): L FAILUR	E					3-4	DAYS
	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter or Jarying Cause (Disease or injury	1 Jan	a consequence of):	MA				4	SEVEE	RAL YRS
8760,	cate be executed physician and the burial-transit	dical Examiner	that initiated events resulting in death) Last		a consequence of): BLEEDING							DAYS
.O. Box 68	The law requires that the death certifical site has been signed by the attending phyage 2 should be detached for use as the	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	B Ectopic pregnancy				23d. Date of o	delivery Day	Year
Q _	quires that I n signed by uld be deta	by	Part II. Other significant conditions co	ontributing to death bu	ut not resulting in the	underlying cause give	en in Part I.	2		o use contribute		
Records,	The law require ate has been si page 2 should b	Completed							4a. Was an autopsy performed?	prior to death	o completic	dings available on of cause of
Vital		Be	25. Was case referred to medical examiner?	Hospital:		cent 3C DOA Oth	0.0	f Death (Che	ack only one)			
Division of	ding Ph h. After thi funeral	tlon; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	ry 2 ER/Outpat ry 28b. Time y Year) Injur	of 28c. Injun	/ at	28d. [5 🗌 Residence Describe how in	6 □Other (S	pecify)	
Divis	iel or Attendes safter death	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	ury - At home, farm, c. (Specify)	street, factory, office		28f. L	ocation (Street lity or Town, Sta	and Number or ate)	Rural Route	e Number,
	To the Hospitel or At within 24 hours after of To the Funerel Directompletely filled in by	edical	one)	ysicien: To the best on niner: On the basis of and manner sta	of my knowledge, def examination and/or			place, and do occurred at				
	To the within To the comple	Z	29b. Signature/and ville of certifier Ouy Out	O Alte	nets	29c. Licenso		0		Date signed (Mo 2/28/05		'ear)
2	(5)	34,5	30. Name and address of Person who of PARMJIT AUJLA			e, Print) POLIS RD.	BLA	ADENS	BURG,	MD. 20	710	
	Sta Registr		31. Date filed (Month, Day, Year) DEC 3 0 2005		ar's Signature				-			

DHMH 17 Rev 1/2001

onens, and

non

	Ernesti		Price Payne 1- State Registrer 1-6-06 Amend		nant PGC cr Ce				ene 0 0 5	43546
\$	• \$ 146		1. Decedent's Name (First, Middle, L	.ast)				2. Date of Death Month		3. Time of Death
	Physici /Medio		Ernesti	ine Price H	Payne			December	23,2005	07:09 A M
	Examin		4a. Facility Name (If not institution, g	ive street and number)	4b. City, Town	, or Location of Death	ח	4c. County of Death	1
			8805 Allentown R	load		Fort Wa	shington		Prince Ge	orge's
	Funeral			Sex 7. A	ge (In yrs. last birthday)	If Under 1 Ye Months Day		8. Date of Birth (Month, Day,	Dec. 23, 9. Birth	nplace (State or Foreign untry)
	Director		579-72-0960		52 Yrs.			Feb. 23,	1953 Wa	sh., DC
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	√anyl f •hc	ក	Maryland Prince	George's		T+	Washingto	-		1 X Yes 2 □ No
	28a-	Director	10e. Street and Number	George 8	.1	10f. Zip Code			g. Citizen of What Co	untry?
	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hygiene. If item 27 ie marked other then "netural", or iteme 23a or 28a-f ehow or other traumatic event, it a Medical Exam ar must be recilled at	ā	8805 A11e	entown Rd.			20744		United	States
	deeth	by Funeral	11. Marital Status	12. Was Deceden	Ever in U.S. 13.	Was Decedent of	of Hispanic Origin? (S uban, Mexican, Puerl	pecify Yes or No-	14. Race - Amer	rican Indian,
9	after or the	교	1 ☐ Never Married 2 ☐ Married	Armed Forces	No	If Yes, specify C 1 ☐ Yes 2 🛣 f		o Hican, etc.)	Black, White	
03	ral', c	by	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates:		1 ⊔ Yes 2LALI	No Specify:		Specify: B	31ack
5-0	72 h	Completed	15. Decedent's (Specify only highest of	Education grade completed)	16a. Dece (Give	dent's Usual Oci	cupation ne during most of wor ired)	rking	6b. Kind of Business/I	ndustry
21	Athin hear.	id	Elementary/Secondary (0-12)	College (1-4or	5+) life.				_	
2	Hygier ther the	S	12th 17. Father's Name (First, Middle, La	-41		Food	Service	ne (First, Middle, M	Govern	ment
anc	2 should be filed withir and Mental Hygiene. ie marked other then aumatic event, it a Mi	Be	Ernest W. T		Tr		10. MOUNET'S NAI		ine Dougla	
Ĕ	should be nd Mental marked c	P	19a. Informant's Name/Relationship	i_		an Addrona /Str	not and Alumbas as Ru		City or Town, State, Z	
Maryland 21215-0036	d 2 si th an 7 ie r traur				2	47 72.5			984	onteness:
	permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tri onca.		Tyrone J. Pr	ice, Jr./S	20b. Place of Dispo cemetery, cre	sition (Name of	let brook		nton, MD Oc. Location - City or	
Baltimore,	Pages nent of the int: If it		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec				Cem. 12/	30/2005	Suitland	MD
들	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice			2. Name and Ad			uneral Hom	
Ba	permit. Departr Importa		12h]	Stansit	TT				Wash., DC	
			23a. Part1. Enter the disease, or co	implications that cause	od the death. Do not en					Approximate
	Dhusisian		shock, or heart failure. List on Immediate Gause (Final	ly one cause on each		'4				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or a	s a consequence of):	ris				
П	Examiner			3 40 10 (61 41	a consequence 517.					
		ě	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	s a consequence of):					
	outed ansit	Ē	Cause (Disease or injury that initiated events	c.						
oʻ	ificate be executed g physicien and as the burial-transit	edical Examiner	resulting in death) Last	Due to (or a	s a consequence of):					
68760,	ite be iysicii ne bu	cat		d						
	- D m		IF FEMALE:							
Box	Jeath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 ☐ Fetal death 3	⊒Ectopic pregna	псу		23d. Date of deli	very Day Year
0.	the a	sici	1 yes 2 No	4□Pregnant a 9□ Unknown	at time of death 5	Other (specify,)		NIOTAL.	buy Tour
9.	requires that the death cert een signed by the attending hould be detached for use a		Part II. Other significant conditions	t contributing to death	but not resulting in the u	indertying cause	gwan in Part I	23e Did tobs	acco use contribute to	the cause of death?
ds,	ires t signe	þ	The state of the s	combaning to dod.	bet not roodking in the c	indonying oddaso	given arrait.	1 □ Yes	. /	obably 4 Unknown
0	w requir been si should	etec								
Records,	e la hes je 2	Completed						24a. Was an autopsy perform	prior to c	topsy findings available completion of cause of
a	iclan: The l certificate he rector, page								ed? death?∕ □ No 1 □ Yes	2 □ No
of Vital		Be	25. Was case referred to medical examiner?	Hospital:				ath (Check only one		
οţ		To	1 ⊋ Yes 2 □ No 27. Manner of Death	28a. Date of Ini	urv 28b. Time o	nt 3 DOA	4 Nursing F	lome 5 Resider 28d. Describe how	oce 6 Other (Spec	15y) Scene
	ding Phy Ih. After thi funeral o	tion	1 Natural 5 Pending 2 Accident investigat	(Month, D	ay Year) Injury	M 1	Nork?		AN Soprem	BY SUV
Division	Atten deat ctor:	fica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Ir	njury - At home, farm, st			28f. Location (Stre	et and Number or Ru	ral Route Number, ND
Ö	Dir	Certification:	4 Homicide	building, e	otc. (Specify)			SPDS ALLEN	State) TOWN RUD FOR	TWISHINGTON
	S = 00	· •							/ 1	1.0

To the Hospital or At within 24 hours effer of To the Funerel Direct completely filled in by

State Registrar

DHMH 17 Rev 1/2001

Medical

(Check only one)

29b. Signature and title of certifier

MARGIARITA

31. Date filed (Month, Day, Year)
DEC 3 0 2005

111 Penn Street, Baltimore, Maryland 21201 2. Registrar's Signature

(W)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

27 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

O.C.M.E.

29c. License number

29d. Date signed (Month, Day, Year)

December 24, 2005

Physician Medical Examiner Jeanette Marie Pause			1 - For State Registrar			epartment of Certificate of	Health and N Death	Reg	2000	43547
Security Security Person of Location of Dearn Security Person of Location Security	Physici	an	Decedent's Name (First, Middle, La	st)				Month	Day Year	3. Time of Death
Note 1 Note 1 Note 2										
Social Search Fundame Sax CM 20/4 9.5 vol. Mortin Gay William Mortin Gay William April 10,1910 2 Benjation of November 20/4	Examin	er					or Location of Death			1
107-42-8138 107-4							. If Dador 24 Hrs	100		
100 State 100 County 100 Copy Town or Location 100 Copy Town or Location 120 Copy 2 100 Copy 2 100 Copy 2 100 Copy 3			107-42-8138			Months Day		(Month, Day, Y	,1910 Cana	nplace (State or Foreig untry) uda
John Beckkerger Tale Informatic Name Politicionship (Type, Print) Joan Evey (Paughter) 15b. Mailing Address (Street and Number or Print) Brown Ruman (Paughter) P. O. Box 176, Preston, Maryland 21655 20b. Mend of Disposition 1 Barrial 2 (Street) and Number or Print Brown Ruman (Paughter) 20b. Mend of Disposition 1 Barrial 2 (Street) and Street (Speedy) 21 Surface of Unity Street (Paughter) 22b. Mend of Disposition (Paughter) 22b. Mend of Market (Paughter) 22b. Mend of Market (Paughter) 22b. Mend of Disposition (Paughter) 22c. Mend of Market (Paughter) 22c. Market (Pau	land				10c. City, Town o	r Location				10d. Inside City Limit
John Beckkerger Tale Informatic Name Politicionship (Type, Print) Joan Evey (Paughter) 15b. Mailing Address (Street and Number or Print) Brown Ruman (Paughter) P. O. Box 176, Preston, Maryland 21655 20b. Mend of Disposition 1 Barrial 2 (Street) and Number or Print Brown Ruman (Paughter) 20b. Mend of Disposition 1 Barrial 2 (Street) and Street (Speedy) 21 Surface of Unity Street (Paughter) 22b. Mend of Disposition (Paughter) 22b. Mend of Market (Paughter) 22b. Mend of Market (Paughter) 22b. Mend of Disposition (Paughter) 22c. Mend of Market (Paughter) 22c. Market (Pau	Many fed	ō	Maryland Caroline		Pre	eston				1X Yes 2 □ N
John Beckkerger Tale Informatic Name Politicionship (Type, Print) Joan Evey (Paughter) 15b. Mailing Address (Street and Number or Print) Brown Ruman (Paughter) P. O. Box 176, Preston, Maryland 21655 20b. Mend of Disposition 1 Barrial 2 (Street) and Number or Print Brown Ruman (Paughter) 20b. Mend of Disposition 1 Barrial 2 (Street) and Street (Speedy) 21 Surface of Unity Street (Paughter) 22b. Mend of Disposition (Paughter) 22b. Mend of Market (Paughter) 22b. Mend of Market (Paughter) 22b. Mend of Disposition (Paughter) 22c. Mend of Market (Paughter) 22c. Market (Pau	1 the	ie C				10f. Zip Code		100	g. Citizen of What Co	untry?
John Beckkerger Tale Informatic Name Politicionship (Type, Print) Joan Evey (Paughter) 15b. Mailing Address (Street and Number or Print) Brown Ruman (Paughter) P. O. Box 176, Preston, Maryland 21655 20b. Mend of Disposition 1 Barrial 2 (Street) and Number or Print Brown Ruman (Paughter) 20b. Mend of Disposition 1 Barrial 2 (Street) and Street (Speedy) 21 Surface of Unity Street (Paughter) 22b. Mend of Disposition (Paughter) 22b. Mend of Market (Paughter) 22b. Mend of Market (Paughter) 22b. Mend of Disposition (Paughter) 22c. Mend of Market (Paughter) 22c. Market (Pau	38 o	0	98 Main Street			21655			USA	
John Beckkerger Tale Informatic Name Politicionship (Type, Print) Joan Evey (Paughter) 15b. Mailing Address (Street and Number or Print) Brown Ruman (Paughter) P. O. Box 176, Preston, Maryland 21655 20b. Mend of Disposition 1 Barrial 2 (Street) and Number or Print Brown Ruman (Paughter) 20b. Mend of Disposition 1 Barrial 2 (Street) and Street (Speedy) 21 Surface of Unity Street (Paughter) 22b. Mend of Disposition (Paughter) 22b. Mend of Market (Paughter) 22b. Mend of Market (Paughter) 22b. Mend of Disposition (Paughter) 22c. Mend of Market (Paughter) 22c. Market (Pau	death ms 2	Jere	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Decedent of	Hispanic Origin? (Sp	ecify Yes or No-		
John Beckkerger Tale Informatic Name Politicionship (Type, Print) Joan Evey (Paughter) 15b. Mailing Address (Street and Number or Print) Brown Ruman (Paughter) P. O. Box 176, Preston, Maryland 21655 20b. Mend of Disposition 1 Barrial 2 (Street) and Number or Print Brown Ruman (Paughter) 20b. Mend of Disposition 1 Barrial 2 (Street) and Street (Speedy) 21 Surface of Unity Street (Paughter) 22b. Mend of Disposition (Paughter) 22b. Mend of Market (Paughter) 22b. Mend of Market (Paughter) 22b. Mend of Disposition (Paughter) 22c. Mend of Market (Paughter) 22c. Market (Pau	urs after el', or ite	þ		1 ☐ Yes 2 📉 If Yes, Give	No			Mican, etc.)		
John Beckkerger Tale Informatic Name Politicionship (Type, Print) Joan Evey (Paughter) 15b. Mailing Address (Street and Number or Print) Brown Ruman (Paughter) P. O. Box 176, Preston, Maryland 21655 20b. Mend of Disposition 1 Barrial 2 (Street) and Number or Print Brown Ruman (Paughter) 20b. Mend of Disposition 1 Barrial 2 (Street) and Street (Speedy) 21 Surface of Unity Street (Paughter) 22b. Mend of Disposition (Paughter) 22b. Mend of Market (Paughter) 22b. Mend of Market (Paughter) 22b. Mend of Disposition (Paughter) 22c. Mend of Market (Paughter) 22c. Market (Pau	2 ho	ted	15. Decedent's E	ducation	16a. D	ecedent's Usual Occi	upation	16	6b. Kind of Business/l	ndustry
John Beckkerger Tale Informatic Name Politicionship (Type, Print) Joan Evey (Paughter) 15b. Mailing Address (Street and Number or Print) Brown Ruman (Paughter) P. O. Box 176, Preston, Maryland 21655 20b. Mend of Disposition 1 Barrial 2 (Street) and Number or Print Brown Ruman (Paughter) 20b. Mend of Disposition 1 Barrial 2 (Street) and Street (Speedy) 21 Surface of Unity Street (Paughter) 22b. Mend of Disposition (Paughter) 22b. Mend of Market (Paughter) 22b. Mend of Market (Paughter) 22b. Mend of Disposition (Paughter) 22c. Mend of Market (Paughter) 22c. Market (Pau	hin 7	be			5+)	fe. DO NOT use retir	e during most of work red)	arig		
John Beckkerger Tale Informatic Name Politicionship (Type, Print) Joan Evey (Paughter) 15b. Mailing Address (Street and Number or Print) Brown Ruman (Paughter) P. O. Box 176, Preston, Maryland 21655 20b. Mend of Disposition 1 Barrial 2 (Street) and Number or Print Brown Ruman (Paughter) 20b. Mend of Disposition 1 Barrial 2 (Street) and Street (Speedy) 21 Surface of Unity Street (Paughter) 22b. Mend of Disposition (Paughter) 22b. Mend of Market (Paughter) 22b. Mend of Market (Paughter) 22b. Mend of Disposition (Paughter) 22c. Mend of Market (Paughter) 22c. Market (Pau	giene giene er the	10				Homemak	er		Own Ho	me
John Bechkerger John Bechkerger John Manaphelauchal (Typa, Party) Joan Evey / Daughter John Manaphelauchal (Typa, Party) Joan Evey / Daughter John Manaphelauchal (Typa, Party) Joan Evey / Daughter Joan Manaphelauchal (Typa, Party) Joan Manap			17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, Ma	aiden Surname)	
Joan Evey /Daughter P. O. Box 176, Preston, Maryland 21655 20a. Method of Disposition (Agency) I Datinal 20a Concention 3 Plantoval from State Controlled (Agency) I Datinal 20a Concention 3 Plantoval from State Controlled (Agency) I Datinal 20a Concention 3 Plantoval from State Controlled (Agency) I Datinal 20a Concention 3 Plantoval from State Controlled (Agency) I Datinal 20a Concention 3 Plantoval from State Controlled (Agency) I Datinal 20a Concention 3 Plantoval from State Controlled (Agency) I Datinal 20a Concention 3 Plantoval from State Controlled (Agency) I Datinal 20a Concention 3 Plantoval from State Controlled (Agency) I Datinal 20a Concention 3 Plantoval from State I Datinal 20a State 3 Plantoval from State 3 Plantoval fr	uld b Venti rrked rtic e		John Bechkerger				Louisa S	Scharbach		
Physician Middled Reason of Completed and Season of Season o	sho s ma	ľ	19a. Informant's Name/Relationship	Type, Print)	19b. A	lailing Address (Stree	et and Number or Rui	ral Route Number, (City or Town, State, Z	ip Code)
Physician Middled Reason of Completed and Season of Season o	and 2 valth 27 I		Joan Evey /Daught	er				n, Maryla	nd 21655	
Physician Middled Reason of Completed and Season of Season o	of He of He roth			Bamaval from State	20b. Place of Cometery,	isposition (Name of crematory or other pi	lace)	Date 20	Oc. Location - City or 1	Town, State
Physician Middled Reason of Completed and Season of Season o	Page nent ont: If				i			/2005 De	elmar, Del	aware
Physician Middled Reason of Completed and Season of Season o	mit. partn sorte / inju		21. Signature of Funeral Service Lice	need 11		22. Name and Add	race of Eacility			
Thysician important and failure. Little the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Come and Bet	20E 20		Trumate	Telle	J	106 Main	Street, Ea	e, P. U. ast New M	arket, MD	21631
FFEMALE: 23c. If yes, outcome of pregnancy 1 1 1 1 1 1 1 1 1	Examine and sician and purial-transit	cal	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	b. Due to () as	sphag alonsequence of ellow	ea naelar	aeei	dent		10 day
1 Yes 2 Sub 3 Probably 4 Unknow 24a. Was an autopsy findings availate prior to completion of cause of death? 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Magner of Death 1 Yes 2 No 28b. Time of injury at work? 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28c. Loruptation of Could not be determined elemented to be determined elemented to be determined elemented (Check only one) 28c. Injury at Work? M 1 Yes 2 No 28c. Loruptation of Could not be determined elemented elemented (Month, Day Year) 28c. Injury at Work? M 1 Yes 2 No 28c. Loruptation of Could not be determined elemented elemented (Month, Day Year) 28c. Injury at Work? M 1 Yes 2 No 28c. Loruptation of Could not be determined elemented elemented (Month, Day Year) 28c. Injury at Work? M 1 Yes 2 No 28c. Loruptation of Could not be determined elemented (Month, Day Year) 28c. Injury at Work? M 1 Yes 2 No 28c. Loruptation of Could not be determined (Month, Day Year) 28c. Injury at Work? M 1 Yes 2 No 28c. Loruptation of Could not be determined (Month, Day Year) 28c. Loruptation of Could not be determined (Month, Day Year) 28c. Loruptation of Could not be determined (Month, Day Year) 28c. Loruptation of Could not be determined (Month, Day Year) 28c. Loruptation of Could not be determined (Month, Day Year) 28c. Loruptation of Could not be determined (Month, Day Year) 28c. Loruptation of Could not be determined (Month, Day Year) 28c. Loruptation of Could not be determined (Month, Day Year) 28c. Loruptation of Could not be determined (Month, Day Year) 28c. Loruptation of Could not be determined (Month, Day Year) 28c. Loruptation of Could not be determined (Month, Day Year) 28c. Loruptation of Could not be determined (Month, Day Year) 28c. Loruptation of Could not be determined (Month, Day Year) 28c. Loru	the death certifica y the attending ph ched for use as th	yslcian/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 200 No	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death		icy			*
24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24b. Were autopsy performed 2 1 Yes 2 No 25c. Was case referred to medical examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 25c. Was case referred to medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 26c. Place of Death (Check only one) 27c. Manger of Death 1 Mospital: Impatient 2 ER/Outpatient 3 DOA 27c. Manger of Death 1 Mospital: Impatient 2 ER/Outpatient 3 DOA 27d. Manger of Death 1 Mospital: Impatient 2 ER/Outpatient 3 DOA 27d. Manger of Death 1 Mospital: Impatient 2 ER/Outpatient 3 DOA 27d. Month, Day Year) 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 29b. Signature apartific of certifier 29c. License number 29d. Date signed (Mospith, Day, Year) 29d. Date signed (Mospith, D	that led by deta	V Ph	Part II. Other significant conditions	contributing to death b	out not resulting in t	ne underlying cause g	given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24b. Were autopsy performed 2 1 Yes 2 No 25c. Was case referred to medical examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 25c. Was case referred to medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 26c. Place of Death (Check only one) 27c. Manger of Death 1 Mospital: Impatient 2 ER/Outpatient 3 DOA 27c. Manger of Death 1 Mospital: Impatient 2 ER/Outpatient 3 DOA 27d. Manger of Death 1 Mospital: Impatient 2 ER/Outpatient 3 DOA 27d. Manger of Death 1 Mospital: Impatient 2 ER/Outpatient 3 DOA 27d. Month, Day Year) 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 29b. Signature apartific of certifier 29c. License number 29d. Date signed (Mospith, Day, Year) 29d. Date signed (Mospith, D	uires n sigr td be							1 ☐ Yes	2 № 0 3 🗆 Pro	bably 4 Unknow
autopsy performand death? 1	> 0 2	lete						24a Wasan	24h Were aut	oney findings availab
25. Was case referred to medical examiner? 1	e ta has	E G						autopsy performs	prior to c	ompletion of cause of
The state of the s	n: Th ficate rr, pa	0	Or Was seen aftered to madical	T				1 ☐ Yes 2	SHo 1 □ Yes	2 No
1	sicie	m	examiner?	Hospital:	0055:0					
28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, building, etc. (Specify) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and Title of certifier and manner stated. 29b. Signature and address of ferson who completed cause of death (Item 23a) (Type, Print) ANNEA AUEN NO 24G. Specify) 28f. Location (Street and Number or Rural Route Number, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, factory, office building, etc. (Specify) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and Title of certifier and manner stated. 29b. Signature and Title of certifier and manner stated. 29c. License number 29d. Date signed (Mopth, Day, Year)	Phys raldi	-			and the second s					ity)
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and manner and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)	ding h. Afte fune	후			ı <i>y Year)</i> Inju	iry W	ork?		, ,	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and manner and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)	or Atten after deat Director: in by the	ertifica	3 ☐ Suicide 6 ☐ Could not b	28e. Place of Inj	jury - At home, farm tc. (Specify)			28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
29b. Signature and Title of certifies 29b. Signature and Title of certifies 29c. License number 29d. Date signed (Mopth, Day, Year) 12705 30. Note and address of ferson who completed cause of death (Item 23a) (Type, Print) ANDREA ALLEN NO 2195. Washing for St East on Min 21601	Mospite 24 hours Funerel stely filled	O	(Check only 2 Medical Exa	miner: On the basis o	if examination and/	leath occurred at the or investigation, in my	time, date and place, opinion, death occur	and due to the cau red at the time, date	ise(s) and manner as e and place, and due	stated. to the cause(s)
30. Note and address of ferson who completed cause of death (Item 23a) (Type, Print) ANDREA ALLEN NO 219 S. Washington St Easton No 2601	o the o the o the omple	Me	201 201 201 201 201 201 201 201 201 201			29c. Licer	nse number	290	d. Date signed (Month	, Day, Year)
30. Notice and address of the son who completed cause of death (Item 23a) (Type, Print) ANDREA ALLEN MD 219 S. Washington St East on MD 21601	F ₹ 5		and of	Whe	mo	D	352F	4	12/27/1	-
ANDREA ACLEN MO 219 S. WESWINGTON STEASTON MIS 2160/		1	30. Nome and address of Person who	completed cause of c	death (Item 23a) (T	rpe, Print)	4 - 6	4 = n+	The han	2/181
			ANDREA ALLE	on mo	219 5.	Washin	gran Si	carl		4601

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** WILLIAM LEE RICHARDSON December 28, 2005 11:30 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4423 72nd Avenue Prince George's Landover Hills If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1X M 2□ F 314-28-4598 76 Director 4, 1929 Indiana Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Itams 23a or 28a-f shov the Madical Experiment sust be notified at 1 Yes 2 No Director Maryland Prince George's Landover Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4423 72nd Avenue 20784 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black. White, etc. filed within 72 hours after Hygiene. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1950-1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced White 1952 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Financial Management Library of Congress permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 Is markad othe any injury or other traumatic event, <u>once.</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Howard Richardson Faye Janet Chapman 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eva J. Richardson - Wife 4423 72nd Avenue, Landover Hills, MD 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ' 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 12/30/2005 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Fart 1. Enter the disease, or templications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic Obstructive Pulmona, Disease 12 years /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): attending physician for use as the buria Compieted by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? the Colon 1 Nes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2 XNo 1 Tyes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 XNo completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 🗌 Pendina 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Greenway Centa Drive Greenbelt 10 20770 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephenie TritoglioAN 7500

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

0 2005

. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

		Please Typ	oe or Print in Black Inc	delible Ink. Ensure A	II Copies A	re Legible.	
	ľ	1 - For Stete Registrar	tate of Maryland / Depa	artment of Health and M tificate of Death	, ,	2.005	+3549
Physicia /Medica		1. Decedent's Name (First, Middle, Last) Lawrence Ellis			2. Date of Death Month December	Day Year 25 2005	3. Time of Death
Examine Funeral Director	er	577-60-9250 Usual Residence of Decedent	ty Hospital 7. Age (In yrs. last birthday) 59 Yrs.	4b. City, Town, or Location of Death Lanham If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y Jan. 18,	, 1946 Wa	George's place (State or Foreign ntry) ash., DC
Marylar e-f ehow	į	Maryland Prince Geo	orge s	cation Capitol Heights			10d. Inside City Limits ↑▼ Yes 2 □ No
th with the 23a or 28	al Directo	10e. Street and Number 319 Carmody Hill	ls Drive	10f. Zip Code 20743	10g	. Citizen of What Cou United	•
ursa ursa	by Funeral	1 Never Married 2 Married	1107 Vas 2 □ No	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	can Indian,
hin 72 ho	Completed	15. Decedent's Education (Specify only highest grade continuous) Elementary/Secondary (0-12)	mpleted) (Give	dent's Usual Occupation kind of work done during most of work OO NOT use retired)	ing 16	6b. Kind of Business/Ir	dustry
be filed will that Hygien of other the	Be	12th 17. Father's Name (First, Middle, Last)		Security Guard 18. Mother's Name	e (First, Middle, Ma	,	
should Mer marks marks	၉	John Russell 19a. Informant's Name/Relationship (Type,	Print) 19b. Mailin	ng Address (Street and Number or Rura		rene Belfi	
and 2 seath ar n 27 le		LaTrice Russell/Da		Carmody Hills Dr.			
porntill Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic ance.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo	20b. Place of Dispo cemetery, cren	natory or other p@em.		c. Location - City or T	own, State
permit. Pa Departmer Important eny injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Fireral Service Licensee △		Veterans 1/5/2 Name and Address of Facility S		Cheltenh neral Home	
Depariming Department of the partment of the p		John I. St	ewar III	4001 Benning Rd.	, N.E. Wa	sh., DC 20	
Pnysician /Medical		23a. Part 1. Enter the disease, or complication shock, or leart failure. List only one commendate Cause (Final disease or condition resulting in death)	Stroke	er the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death Lours
Examiner	_	Sequentially list conditions, b.	Due to (or as a consequence of): Card works Due to (or as a consequence of):	Melletus			yeens
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	D: a viles Due to (or as a consequence of):	Melletus			years
ficate be physicials the bu	edical	d					
To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	Physician/Medic	in the past 12 months?		Ectopic pregnancy		23d. Date of deliver Month	ery Day Year
quires that in signed build be dete	2	Part II. Other significant conditions contrib	uting to death but not resulting in the ur	nderlying cause given in Part I.		cco use contribute to t	
i: The law requir cate has been si page 2 should	Completed				24a. Was an autopsy performe	24b. Were autoprior to codeath?	psy findings available mpletion of cause of 2 No
s certif	o Re	25. Was case referred to medical examiner? 1 Yes 2 No	ital: 1 Inpatient	Others	Check only one	ce 6 Other (Specia	L.1
To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification; I	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	8a. Date of Injury 28b. Time of Injury Injury		28d. Describe how		<i>y</i>)
ital or Att rs after de ral Direct led in by t	Certific		8e. Place of Injury - At home, farm, stre building, etc. (Specify)		City or Town, S		
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	one)	in: To the best of my knowledge, death On the basis of examination and/or inv and manner stated.	restigation, in my opinion, death occurr	and due to the caused at the time, date	se(s) and manner as s and place, and due to	tated. o the cause(s)
Co No Co	4	29b. Signature and title of certifier	Renesa N	29c. License number 19444		Date signed (Month,	
		30. Name and address of person who completed REM SEN M.	eted cause of death (Item 23a) (Type, i	10 D 19444 Print) TREET 50178 3	51 LAU	NEC, MO	20707
State Registra	-	31. Date filed (Month, Day, Year) DEC 3 0 2005	7. Registrar's Signature	&			

			1 - For State Registrar	State of Marylan		artment of F		Mental Hygien	11113	43550
	B		1. Decedent's Name (First, Middle, Last	9				2. Date of Death Month D	ay Year	3. Time of Death
	Physici /Medic		LeRoy Ree	ves					25 2005	
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Dea	th 4	c. County of Dea	ath
			Prince Georg			If Under 1 Year	Chever1			e George's
	Funeral		5. Social Security Number 6. Se	X M 2□ F	Vec	Months Days	Hours Min	. (Month, Day, Yea.		rthplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	7	U		3	May 25, 19	935 Pe	nnsylvania
	yland		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	e Mar	ctor	Maryland Prince	George's		Mi	tchellv:	ille		1 X Yes 2 □ No
	ith th or 28	Director	10e. Street and Number			10f. Zip Code		10g. C	itizen of What C	ountry?
	ath w	rall		ral Court			20721		United	
	er de Itam	nue	11. Marital Status 1 ☐ Never Married 2 🛣 Married	12. Was Decedent Ever in U Armed Forces? 1 XYes 2 □ No	.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (: an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh	
36	Irs aft	by Funeral	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify:	Black
Ö	2 hou	ted	15. Decedent's Edu	ucation	16a. Dece	dent's Usual Occup	ation	16b.	Kind of Busines:	s/Industry
21215-0036	thin 7	ple	(Specify only highest grad	College (1-4or 5+)	life.	kind of work done DO NOT use retired	during most of wo	orking		
7	ed wi	Completed		2 A.A.		Graphic	Illustr		Gover	nment
pu	be fill d off	Be	17. Father's Name (First, Middle, Last)	1 5			18. Mother's Na	rme (First, Middle, Maide		
2	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Itams 23e or 28e-f show aumatic evant, the Medical Energian remails ovant.	မ		hew Reeves	40h Maili	Add (C44		Elizabeth		
Ma	and 2 st ealth and n 27 is r		19a. Informant's Name/Relationship (T) Rosetta Reeves					iural Route Number, City chellville,		721
ē,	- T = =		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of	1		Location - City o	
JO L	Pages nent of h ant: If its ary or of		1 🕅 Burial 2 □ Cremation 3 □ I 1 □ Donation 5 □ Other (Specify,	Removal from State	-	matory`or other plac Veteranc	- 1	/4/2006 C	heltenh	om MD
Baltimore, Maryland	permit. I Departm Importar any inju		21. Signature of Huneral Service Licens		-	2. Name and Addre		Stewart Fune		
Ď	permi Depar Impor any ir		10 en 1.	Meway, III		4001 Be		l., N.E. Was		
			23a. Par 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the deat	h. Do not ent	er the mode of dyin	ng, such as cardia	c or respiratory arrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Seizure D	isorde	r				Onset and Death Months
	/Medical Examiner		resulting in death)	Due to (or as a conseq						
	LAMITME	_	Sequentially list conditions, if any, leading to immediate	Adrenal I		ency				Weeks
	led Isit	Examiner	Cause (Disease or injury	Due to (or as a conseq						Months
	al-tra	xar	that initiated events resulting in death) Last	c. Due to (or as a conseq						HOHEHS
8760,	Attending Physician: The law requires that the death certificate be executed refath. retath. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	call		Metastatio	Lung	Cancer				Years
9	tificat ig phy as thi				151/100					
Вох	leath certific attending p	an/N	23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy	,		23d. Date of de	,
O. B.	ed fo	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time of d		Other (specify)			Month	Day Year
<u>Ч</u>	res that the de signed by the a be detached f	Physician/Med	9 Unknown Part II. Other significant conditions co		ulkina in the co		an in Bankl	22a Didahasa		o the cause of death?
S,	signe d be o	l by		tive Lung Dise	-	riderlying cause giv	enarranti.			robably 4 Unknown
Ö	w require been sig should b	etec	Obberde	CIVE Hang Disc	-450			71		
Records,	has ge 2	Completed						24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
ā	in: Ti ificate or, pa	e Co	25. Was case referred to medical				26 Plans of Do	performed? 1 □ Yes 2 ☑ N	o 1 🗆 Ye	s 2 No
5	ysicia s cert direct	To B	examiner?	Hospital: 1 Inpatient 2 🗆	ER/Outpatier	nt 3 DOA Oth		ath (Check only one) Home 5 ☐ Residence	6 ∏Other (Sne	- acity)
0	g Phy ter thi		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		y at	28d. Describe how inju		Joney
jo	andin ath. or: Af	atio	1 ♣ Natural 5 ☐ Pending investigation		injury		Yes 2 □ No			
Division of Vital	of or Attendated after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, sti	eet, factory, office		28f. Location (Street a City or Town, Sta		lural Route Number,
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		22 0 27					1		
	Hosp 24 hol Funs stely fi	Medical	29a. Certifier (Check only one) 1X Certifying Phy 2 Medical Exami	/sician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the tir vestigation, in my o	ne, date and plac pinion, death occ	e, and due to the cause(: urred at the time, date ar	s) and manner a nd place, and du	s stated. e to the cause(s)
	To the Hospitel within 24 hours a To the Funeral I completely filled	Mec	29b. Signature and title of certifier	una mannor stated.		29c. Licens	e number	29d. D.	ate signed (Mon	th, Day, Year)
ŀ	⊢ 3 ⊢ ŏ		1/72	2		D	31069			26, 2005
2 11	0 (6)		30. Name dress of person who c	ompleted cause of death (Iter	n 23a) (Type,	Print)				
N			1111111111	e Bone, M.D.			e Lane.	#135. Largo	<u>MD</u> 20	0774
	Sta Registr		31. Date filed (Month, Day, Year) DEC 3 0 2005	2. Registrar's Signa	iture-	_		,		

68760,
Вох
P.O.
Records,
Vital
of
Division

		Please	Type or Print					•	_	•
		For State Registrar	State of Ma	ryland /		artment of F tificate of			neg. No.	43551
Physicia		1. Decedent's Name (First, Middle, La. Jay Kenneth	Rightno	our				2. Date of Dea Month DECEMB	Day Yea	3. Time of Death 4:50 P M
/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, o	r Location of Death		4c. County of De	
		CIVISTA MEDICAL 5. Social Security Number 6. S		(In yrs. last b	oirthday)	LAPL.	ATA if Under 24 Hrs.	8. Date of Birtl	CHARLES	irthplace (State or Foreign
Funeral Director			XM 2□F	96	Yrs.	Months Days	Hours Sept	ember		PA
yland		10a. State 10b. County		10c. City, To	wn or Lo	cation				10d. Inside City Limits
Ba-f si	ctor	MD Char	les	L	a Pi	lata				1 ☐ Yes 2 ☐ No
th with th	Funeral Director	5519 Little Br	ook Drive	2		10f. Zip Code 20	646		10g. Citizen of What (Country?
Jrs a	þ	11. Marital Status 1 Never Married 2 Married Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1x Tyes 2 No 1x Yes, Give Year or Dates:		1	Was Decedent of H f Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, nite, etc. white
72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16	a. Deced	dent's Usual Occup	pation during most of worki	ng	16b. Kind of Busines	ss/Industry
within iene. then	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)		Master :	*		US Ai	r Force
uld be filed Aental Hyg rked othar tic event,	To Be C	17. Father's Name (First, Middle, Last, Charles Right					18. Mother's Name	(First, Middle, e Noon		
2 should and Notes and Not		19a. Informant's Name/Relationship (r, City or Town, State						
1 and Health em 27 ther tr		Gertrude Barna 20a. Method of Disposition	s/Daughte			Little		r. La	Plata, MD	
Pages nent of I int: If it ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specif		cemet	erv. cren	natory or other place	ce)		rlington	
permit. P Departm Importar any injur		21. Signature of Funeral Service Licer		945		. Name and Addre		UNERAL	HOME,P.	Α.
		23a. Part1. Enter the disease, or com	plications that caused the	he death. Do	not ent	O. BOX	567, LA	PLATA r respiratory and	<u>MD 2064</u>	Approximate
Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line	Ibdo	min	al ale	es will	1 Simi	<u></u>	Interval Between Onset and/Death
/Medical Examiner		resulting in death)	Due to (or as a	consequence	e of):		1,00001	- 400	7	7 000
_	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	b. — Due to (or as a	consequence	e of):					
executed in and rial-transit	Examiner	that initiated events	C							
be exercian ar		resulting in death) Last	Due to (or as a	consequence	e of):		·			
ficate I physics the b	adlog	•	d							
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: Atter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal deat		Ectopic pregnancy Other (specify)	,	····	23d. Date of d Month	elivery Day Year
s that	y Ph	Part II. Dther significant conditions of	ontributing to death but	not resulting	in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
w require been sig should b	ted	Prost	ale Clev	on 1	1 2) `		1 🗆 Y	es 2 No 3 1	Probably 4 @Unknown
eicien: The law is certificate has builrector, page 2 sh	Completed						<u>. </u>	24a. Was a autops perfor	med death:	autopsy findings available o completion of cause of
cien: ertifica octor, p	BeC	25. Was case referred to medical examiner?					26. Place of Death			35 2 1 100
Physic this co	P L	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient		utpatien Time of		1 1 1 to 1 to 1 to 1		ence 6 Other (Sp	pecify)
nding th.: After funer	Certification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year)	Injury	Wor	yat k? Yes 2 □No	od. Describe III	ow injury occurred	
r Atter er dea rector by the	tiflea	3 Suicide 6 Could not b	28e. Place of Injury building, etc.	y - At home, ((Specify)	farm, stre	eet, factory, office	2	28f. Location (S City or Town	treet and Number or I	Rural Route Number,
urs aft arel Di										
To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of niner: On the basis of e and manner state	xamination a	ge, death ind/or inv	occurred at the ting to the converse of the co	ne, date and place, a pinion, death occurre	and due to the c ad at the time, d	ause(s) and manner a late and place, and di	as stated. ue to the cause(s)
To the to the company	Ž	29b. Signature and little of certifier	11 000			29c. Licens		2	9d. Date signed (Mor	
		1 / 0//	Holl	/		D-02	975		12-1	7-05
Henrigh		30. Name and address of person who DANIEL M. HOWELL,N					10% 1.741 0	ODE MIN	20602	
Stat	te	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	L	forte	104 WALD	OKF,MD.	20003	
Registra	ar	DEC 3 0	2005	is d	1	gover				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** December 25, 2005 Patricia Peters Robinson 9:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3104 Asher Drive Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 15, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Months Days Min. Hours 1 ☐ M 2 🛣 F 081-30-0208 Director 1938 New York Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar cust be notified at Maryland Anne Arundel Annapolis Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3104 Asher Drive 21403 U.S.A. Items 23a death v Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 72 hours after 1 Never Married 2004 Married 2X No ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: à Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education ges 1 and 2 should be filed v t of Health and Mental Hygie If item 27 Ia marked other t 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ouentin I. Peters Hester D. Rogers ౖ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert D. Robinson/husband 3104 Asher Drive Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 12/29/2005 Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LUNG CANGER TIMS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed burial-transit Due to (or as a consequence of): attending physicien Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an med? 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner' Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 Yes 2€No 2 this the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the Certification: ₩ Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D08118 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 910 BESTEAME RO ANABOULIS mo ZITUT WATEINS STANLEY MO . Registrar's Signature 31. Date filed (Month, Day, Year) State **DEC 2 8 20**05 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 18, December HERBERT CARLTON SMITH 2005 7:59 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 4, 1918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 X M 2 ☐ F Pennsylvania 87 Director 189-03-3680 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show Item 27 is marked other than "neturel", or items 23a or 28a-f sho other treumatic event, the Madical Exambar must be trafficed at 1 ☐ Yes 2 No Director Maryland Prince George's Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3142 Gracefield Road, #301 20904 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give WWI] 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married WWII 1 ☐ Yes 2 🗓 No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wind Department of Health and Mental Hygien Importent: If Item 27 is marked other the any injury or other treumatic event, Ing. 4 Pharmacist AARP (Pharmacy Service) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Worthie Ashton Smith Edith Pauline Cleaver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3142 Gracefield Road, #301, Silver Spring, MD 20904 Mary Smith - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington Cemetery 12/22/2005 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue, Hyattsville, ND 20781 Atome, 1 inch 23 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration Pneumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Incarcerated Hernia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician lan/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🎹 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform page this certificate 1□ Yes 2 🛛 No uneral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No 1 🔀 Inpatient Certification: To 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Attending Physicien: death Director: Hospitel

Baltimore, Maryland 21215-0036

completely filled in by within 24 hours a To the Funerel (Medical 9

State Registrar 4 - Homicide

(Check only

2 Medicat

31. Date filed (Month, Day, Year)
DEC 3 0 2005

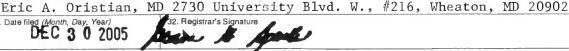
ertifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

one)

29b Signature



1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

December 28, 2005

29c. License number

D24564

		1 - State Registrar 1. Decedent's Name (First, Middle, Last,	State of Marylan		artment of I		Re	ag. No.	43554
Physici /Medio Examin	cal	Wilfred Sterling 4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of De	2. Date of Death Month Dec. 23,	Day Year	3. Time of Death 5:30 P
Funeral Director		Manor Care 5. Social Security Number 577-22-1283 Usual Residence of Decedent	x ŠM 2□F 7. Age (In yrs. 85	last birthday) Yrs.	Potomac If Under 1 Year Months Days	If Under 24 H	in (Month Day	Montgome 9. Birth Cor 1920 Wash	place (State or Fore
tha Maryianu 28a-f show Fulfiked at	ector	10a. State 10b. County Maryland Montgomer 10e. Street and Number		y.TownorLo	Spring				10d. Inside City Limi
J winn 72 hours after death with the Maryland jiene. Tthen "natural", or Itams 23a or 28a-f show It e Madical Examirat must be molified at	by Funeral Director	15101 Interlachen	Dr. #814 12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		10f. Zip Code 20906 Was Decedent of Hif Yes, specify Cub. 1□ Yes ※☑ No	dispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	U.S.A. 14. Race - Amer Black, White	ican Indian, , etc.
Mithin ane. then *	mpieted	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation	(Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of v	working	16b. Kind of Business/li 0i1 Compa	,
be filed tal Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, Last) Alex Sterling	•			Vera	lame (First, Middle, M	faiden Sumame) 1e	
Fages 1 and 2: ment of Health ar sort: If item 27 is ury or other treu		19a. Informant's Name/Relationship (Ty Maxine Srole/Niece 20a. Method of Disposition 1 □ Burial 2★ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Removal from State For	12229 lace of Dispo emetery, crea t Linc	Seline sition (Name of natory or other place coln Crem	Way Pot	omac, MD 2 Date 2/29/2005	City or Town, State, Zo 0854 20c. Location - City or T Brentwood, n Funeral	own, State
nysician		23a. Part1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	3. Do not ent	01 Blade	nsburg l	Rd. Brentw	ood, MD 20	
Medical personned on executed the entired on executed the entired of the entired transit of	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Classas or injury	Due to (or as a consequence of the consequence of t	uence of):					
a attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	.3c. If yes, outcome of pregna 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of deliv Month	өгу Day Year
as been signed by the 2 should be detache	by	Part II. Other significant conditions cor	ntributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.		acco use contribute to t	
ate ha	Completed						24a. Was an autopsy perform 1 Tyes 2	prior to co ed? death?	opsy findings availab impletion of cause of 2 (No
After this funeral di	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 ☐ Inpatient 2 ☐ I 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injur Wor	er. 4 Nursing	eath (Check only one Home 5 Resider 28d. Describe how	nce 6 □Other (Specia	(y)
office of the by the by	i Certification;	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	")		4	City or Town,		
within 24 hours at To the Funeral I completely filled	Medicai	(Check only one) 2 Medical Examin	sician: To the best of my knowner: On the basis of examinat and/manner stated.	wiedge, death ion and/or inv	restigation, in my o	pinion, death oc	curred at the time, dat	use(s) and manner as s te and place, and due t d. Date signed (Month,	o the cause(s)
To	_		\						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month **Physician** 7:56AM^M Johnny G. Sykes December 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9708 Locust Lane Lanham Prince George's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 10XM 2□ F Sep. 22, 1926 Director 79 Georgia 578-34-9210 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State r than "natural", or Items 23a or 28a-f show the Medical Exercises results to rediffed at 1 X Yes 2 □ No Director Prince George's Maryland Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9708 Locust Lane 20706 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th Machinist Operator II AFL-CIO Pages 1 and 2 should be filed nent of Health and Mental Hygis int: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Gordon Sykes Lissieand Daniels 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9708 Locust Ave., Lanham, MD Elaine M. Sykes / Wife 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 12/29/2005 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home Dewar 4001 Benning Rd., N.E. Wash., DC 20019 Norw 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Puse (Final disease or condition resulting in death) **Physician** Metastatic Cancer Pancreas 1 Year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy lor Month Year in the past 12 months? 4☐Pregnant at time of death 9☐ Unknown 5 Other (specify) ☐ Yes 2☐ No 9 Unknown as been signed by 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 🗓 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 1 ☑Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD15185 December 28, 2005 30. Name and address of person who completed cause of death Jtem 23a) (Type, Print) 1150 Varnum St., N.E. #104, Wash., DC 20017 John E. McKnight, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar DEC 3 0 2005

			1 — For State Registrar	State of Maryland		rtment of Hetificate of L			ene 2005	43556	
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death	
Н	Physici /Medic		Joseph	Sartori, J	r.			December		9ar 05 8:29 P A	N
	Examin		4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of Death		4c. County of		
			Southern Maryland	Hospital		Clinto			Prince	George's	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday) _ Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) July 3,	(ear) 9.	Birthplace (State or Foreig Country)	חנ
	Director		Usual Residence of Decedent	M 2L F 79	115.			July 3,	1926 Pe	ennsylvania	
	land w #	1	10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits	s
	Many	ţ	Maryland Prince Ge	orge's Uppe	er Mar	1boro				1 ☐ Yes 2X☐ No	0
	r 282	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of Wha	it Country?	
	23a c	alD	6504 Tiffin Court			20772			U.S.A.	•	
	r dea	Funeral	T. Maria States	Was Decedent Ever in U.S. Armed Forces?	. 13. W	as Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.	
36	s afte	by Fu	1 Never Married 2 Married 3 XWidowed 4 Divorced	1 ØYes 2 □ No If Yes, Give	1	□ Yes 2 No	Specify:		Specify:		
Ö	hour ture!	ed b	15. Decedent's Educa	Year or Dates:	16a Deced	ent's Usual Occupa	ition	16	b. Kind of Busin	White	
5	in 72	Completed	(Specify only highest grade	completed)	(Give k	and of work done d O NOT use retired)	uring most of work	ung	D. King of Dusin	ess moustry	
212	yiene r the	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Sa	lesman			Retail	I	
힏	be filed within 72 hours after death with the Maryland all thygiene. It has a set of other than "neturel", or iteme 23a or 28a-f show other than "neturel", or iteme 23a or 28a-f show event, the Medical Examinar mant to notified at	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, Ma	iden Sumame)		
<u>la</u>	Ments Ments arked	2	Joseph Sartori, S	r.			Mary Cal	lovini			
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship (Type			1000		al Route Number, (
2	l and lealth m 27 her tr		Janice Harich / Da		11700	Troy Cou		lorf, Mar	land, 2	20601 v or Town, State	
Baltimore,	ges I it of F if ite or of		20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Re	cen	netery, crem	atory or other place	9)				
ţ	t. Pertant	- 4	4 Donation 5 Other (Specify)							Maryland	_
Bal	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mendal Hygiene. Department of Health and Mendal Hygiene. Department of Health and Mendal Hygiene and the Hygiene and the Mendal Hygiene and the standard and any injury or other treumatic event, the Mendal Examinational Canadities and Once.		21. Signature of Funeral Service Licenser	M01246		Name and Addres	•	P.O. Box		nd 20604	
			23a. Part1. Enter the disease, or complic	ations that caused the death.						Approximate	
	Dhusisian		shock, or heart failure. List only one Immediate Cause (Final	cause on each line.						Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseque	C of):	ENCO	pullbo	nony			
	Examiner			Due to (or as a conseque	vva	rolar	ACC	1 dent			
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):						
	acute ind trans	Examin	Cause (Disease or injury that initiated events c. resulting in death) Last	Ath orus	()65	ob'c	hean	4 d1 81	9-2100		
8760,	cate be executed physicien and the burial-transit	Ē	resulting in death) cast	Due to (or as a conseque	ince of):						
87	physic the b	dlcai	d.								
9 X	ding ding se as	/Me	IF FEMALE: 23	c. If yes, outcome of pregnant	cv				23d. Date o	f delivery	
P.O. Box	etter etter for u	Physician/Me	in the past 12 months?	1 Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea	leath 3 🗆	Ectopic pregnancy Other (specify)			Month Month	Day Year	
o	the d ached	hysi	1 Yes 2 No 9 Unknown	9□ Unknown							
٠, ت	w requires that the death certifice been signed by the ettending I should be detached for use as	by P	Part II. Other significant conditions cont						cco use contribu	ite to the cause of death?	
ğ	equire en sig ould b	edt	Seizure 2	new on set	h : (to see on	Artem	1 ☐ Yes	2 No 3[☐ Probably 4 ☐Unknow	л
Division of Vital Records,	hes bei	Completed	Seizure, 2	P CABG.	<u> </u>	sami e	obs fine	24a. Was an	24b. Wer	e autopsy findings available r to completion of cause of	е
ď	The ete h page	Con	Lalma dis	onse con	nake	hila he	WIT Fai	performe /vox1 ☐ Yes 21	d? deat	th? Yes 2□ No	
ita	cien: ertific actor,	Be	25. Was case referred to medical	,	7		26. Place of Deat	h Check only one			-
of	Physi this c ai dira	5			R/Outpatient	3 DOA CTHE	4 Nursing Ho	ome 5 Residen		Specify)	_
u C	Jing I	lon	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ? 'es 2 □No	28d. Describe how	injury occurred		
isi	deatl deatl ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hom	ne. farm. stre		05 2 2 1.10	28f. Location (Stre	et and Number o	or Rural Route Number.	-
	after Dire	Certification:	4 Homicide	building, etc. (Specify)		,,		City or Town,	State)		
	To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours attendeath: within 24 hours attendeath: After this certificete has been signed by the estending the the tothe Funderial Director. After this certificete has been signed by the estending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Physi	cien: To the best of my knowl	ledge, death	occurred at the tim	e, date and place,	and due to the cau	se(s) and manne	er as stated.	
	the H in 24 he Fr	edicai	(Check only 2 Medical Examinations)	er: On the basis of examination and manner stated.	on and/or inv	estigation, in my op	inion, death occur	red at the time, date	and place, and	due to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier			29c. License	number	290	. Date signed (A	fonth, Day, Year)	
)			13/100	my		J D 3	10035		12/26/	05	
	0 1 = 11		29b. Signature and title of certifier SIGUA 30. Name and address of person who con BASIR MOHM 31. Date filed (Month, Day, Year) DEC 2 9 2	apleted cause of death (Item 2	23a) (Type, F	Print)	9135 (Pi's coto	way 1	Kd, #316	
1	1P 15+1	•	31. Date filed (Month. Dav. Year)	32. Registrar's Signatu	re .	0	CHINT	UN, M	1) '20	137	
	Sta Registr	ie ar	DEC 2 9 2	005	K.	parte					

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CYNTHIA M. SHULTZ **DECEMBER 29 2005** 1940 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 29590 KENT AVE EASTON TALBOT Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days 1 XM 2 □ F Months 118-34-0422 Yrs. Director 64 NEW YORK Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examinar must be molified at 10d. Inside City Limits MD TALBOT EASTON Director 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29590 KENT AVE. 21601 death Funeral USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural; or Itan any injury or other traumatic event, the Medical Evant Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes T☐ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 OFFICE MANAGER **ENVIRONMENTAL SERVICES** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HORACE A. SPENCER ပ ENA M. BUSKIRK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH A. SHULTZ/HUSBAND 29590 KENT AVE., EASTON, MD 21601 20a. Method of Disposition
1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ARLINGTON NATIONAL 4 ☐ Donation 5 ☐ Other (Specify) 1/11/2006 ARLINGTON, VA 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 Oshows Cf.SO Joseph 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause an each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw erval Between set and Death Breas Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury Due to (or as a consequence of): Examiner th certificate be executed ed by the altending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. ☐Yes 2☐No 9□ Unknown 9 Unknown ate has been signed by I page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 □Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an 2 No 1 Yes Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manner Jeath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 Stural 5 Pendina 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 29c. License number molto 30. Name and advess of person who completed cause of death (Item 23a) (Type, Print) ROBERT J. SMOLOSKI M.D. 609 DUTCHMANS LANE, EASTON, MD 21601 31. Date filed (Month, Day, Year) Registrar's Signatur State 3005 E 0 MAL Registrar

				State of Maryla		irtment of I <i>tificate of</i>		Mental Hy	/giene Reg.No∩ ∩	Arra Bridge	3558
			1. Decedent's Name (First, Middle, La	st)				2. Date of Do	eath	- Ber	3. Time of Death
	Physic /Medi		Odess	sa Thomi	SON			Month 12	Day 26	Year 05	1730am
1	Exami		4a. Facility Name (If not institution, giv	e street and number)	800 barg	oRd.	4b. City, Town, or	Location of Deal	th 4c. County		(13-011)
			Thanor Car	e largo	o voc. y) 0 / 0.	Lourge	0	+	>. (a	
	Funeral		Social Security Number 6. S	ex 7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth av Year)	9. Birthpla	ace (State or Foreign
	Director		244-68-9928	8	5 Yrs.		1,100.0	June 3	1920	South	n Carolina
	and **		Usual Residence of Decedent 10a. State 10b. County	100.	City, Town or Loc	eation				10	d. Inside City Limits
	Maryl f shc	5	W 1 1 D		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1			10	1 X Yes 2 □ No
	28e	Director	Maryland Prince (-eorge's	·	10f. Zip Code	Chever1	У	10g. Citizen of	What Count	n ₁ ?
	3a or		5735 Euclid 8	2+		Toi. Zip Code	20785				•
	filed within 72 hours after death with the Maryland Hygiene. ther then "netural", or Items 23a or 28e-f show ent, the Medical Examinet must be notified at	by Funeral	11. Marital Status	12. Was Decedent Ever in	U,S. 13. W	as Decedent of H		Specify Yes or No		ted St	
0	or Ite	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2X No			lispanic Origin? (S an, Mexican, Puer	to Rican, etc.)	Bia	ck, White, e	
02	al', o	þ	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	☐Yes 21/Q No	Specify:		Specif	v:	erican
21215-0020	72 hc	Completed	15. Decedent's Ed (Specify only highest gra	ucation	16a. Decede	ent's Usual Occup	eation during most of wo	efeter -	16b. Kind of B		
2	ithin en en	흗	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retire	d) most or wo	rking			
	ygier ygier her th	ပ်	6th			Co	unselor		P	rivate	9
and	be fill d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle		-,	
3	should be filed with nd Mental Hygiene. marked other ther umatic event, the	ဥ	Tom McDowe						ea Baxt		
Maryland	2 L L S		19a. Informant's Name/Relationship (7) Madge T. Gonzale				and Number or Ri				Code)
	1 an Heal sm 2		20a. Method of Disposition		. Place of Disposi		Ave., W	Date	MD 209		m Ctata
Baltimore,	ges if it		1 Burial 2 □ Cremation 3 □	Removal from State	cemetery, crema	atory or other place	-				
Ħ			4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service License		Mt. Oliv	Vet Ceme: Name and Addre		12/31/05		h., DC	3
Ba	permit. Departminimporta any inju			# +	7		enning Ro	Stewart			0010
	_		23a. Part 1. Inter the disease or composhock or heart failure. List only of	Meway J							
1	Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death)	a Cerebron	vas culu (or as a consequ	ar ac	ciden.	L			Approximate nterval Between Onset and Death
	cuted nd ransit	Examiner	Sequentially list conditions	b. Orynerte	(or as a conseque	ence of):					
Ö,	tificate be executed g physician and as the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Cre 10		1				į	
68760,	ate br	edical	that initiated events resulting in death) Last	C. Due to	(or as a conseque	ence of):	-				
	entific ling p			a Dumen	La					1	
Вох	ath ce	lan/		a. ~						1	
P.0.	The law requires that the death centate has been signed by the attendingage 2 should be detached for use	Physiclan/M	Part II. Other significant conditions co	ntributing to death but not re	sulting in the und	lerlying cause give	en in Part I.	23b. Did 1	obacco use cor	tribute to t	he cause of death?
٦.	res that the signed by be detacted							10	Yes 2 No	3 Proba	bly 4 □ Unknown
,ds	uires n sign ild be	d by				,		24a Was	an autopsy	24h Were	autopsy findings
2	ie law require i has been sig ge 2 should b	Completed							med?	availa	able prior to pletion of cause
2	he lar e has age 2	Ĕ								of de	
<u>ta</u>	in: T		25. Was case referred to medical				00 Diagraf Day	1 7	1.0	1 1	ies 219-HU
≥ .	ysicis s cert direct	To Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	TER/Outpatient	3□ DOA Othe	28. Place of Dea	ome 5□Resio	*	or (Conside)	
ō	g Phy er thi		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury	at		ow injury occurr		
Ö	Attending Physician: r death. sctor: After this certific by the funeral director,	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(WORLI, Day Year)	Injury	M 1□	Yes 2□No				
	9 # ¥ ≅ □	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stree ify)	t, factory, office		28f. Location (5 City or Tow	Street and Numbern, State)	er or Rural F	Route Number,
:	To the Hospital or within 24 hours afta To the Funeral Dir completely filled in	edical (29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kn ner: On the basis of examina and manner stated.	wledge, death o ation and/or inves	ocumed at the tin stigation, in my op	o, date and place, pinion, death occur	and due to the c red at the time, o	aues(e) and ma date and place, a	nner as state and due to th	ed. ne cause(s)
;	withir To th	Me	29b. Signature and title of certifier		-3	29c. License	number		29d. Date signed	(Month, Da	y, Year)
			1 9. 400	0 9		Doo	62116		12/28	1 0 1-	
17	16)		30. Name an address of person who co	ompleted cause of death (Ite	m 23a) (Type, Pri		04110		10/ 58	100	
		. 1		LNEH , 7:		•	ER PAR	KWAY	. GREE	WBE	LT, MD
	Stat Registra		31. Date filed (Month, Day, Year)	3 Registrar's Sign	ature	et,		,	,		

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Maryland		artment rtificate			nd Menta	l Hygien		43559
	Physici /Medi		1. Decedent's Name <i>(First, Middle, Last,</i> Louise		lley	7			2. Date Mor 12	25	ay 2005	12:42 PM
	Examir		^{4a.} Facility Name (If not institution, give Laurel Regiona	l Hospital		4b. City, 1 Lau		ocation of [Death	P ⁴	c. County of Dear PINCE (George's
	Funeral Director		5. Social Security Number 6. Set 578-40-2725	7. Age (In yrs. las	t birthday) Yrs.	If Under Months		If Under 24 Hours	Min. (Mo.	of Birth nth, Day, Yea /01/1	9. Bi	rthplace (State or Foreign country) irginia
	e Maryiand 8a-f show Hilled at	ctor	10a. State 10b. County MD Prince C	George's Lat	Town or Lo	ocation						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	th with the	Funeral Director	9250 Cherry La	ne		10f. Zip	Code 0707	7			itizen of What C JSA	country?
900	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Is marked other then "natural", or Itams 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 🎛 Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1		Was Decedent Yes, special Yes 2		panic Origin , Mexican, F Specify:	n? (Specify Ye Puerto Rican, e	s or No- etc.)	14. Race - Am Black, Wh Specify B1	ite, etc.
21215-0036	within 72 h ine. Ihan "natu is Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life.	dent's Usual kind of word DO NDT use Lnist	k doné du e retired)	uring most o	f working		Kind of Business	s/Industry ernment
land 2	2 should ba filed withi and Mental Hygiene. Is marked other than aumatic event, the M	To Be Co	17. Father's Name (First, Middle, Last) Page Randooph	03 Barbour	Adm	LIIISC		18. Mother's	Name (First,	Middle, Maide	en Sumame)	ermment
, Maryland	1 and 2 shou Health and N tem 27 Is mai		19a. Informant's Name/Relationship (Ty Mary Jarvis -								or Town, State, DC 2	
altimore,	t. Page rtment o rtant: If njury or		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Signify re of Funeral Service License	emoval from State Gate	etery, crer e of	sition (Naminatory or other Heav Name and Name and	her place, 'en	12	Date 2/30/0	5 Wh	Location - City o eaton , 831 Ga	
B	Depa Impo any ir		23a. Parti. Enter the disease, or compl	(LGM)					ral Ho	me W	ash.,	•
	Physician /Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Respirat Due to (or as a conseque	cory			, 30011 43 04		atory arrost,		Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or se a consequen	nce of):							
.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deal	eath 3	Ectopic pre Other (spe					23d. Date of de Month	alivery Day Year
rds, P	quires that n signad b uld be deta	by	Part II. Dther significant conditions cor	ntributing to death but not resulti	ng in the u	nderlying ca	use giver	n in Part I.	236			to the cause of death?
Il Records,		Completed								a. Was an autopsy performed?	prior to death?	
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes X No	lospital: 1 □ Inpatient 2 🛣 EF	∛Outpatier	it 3□ DO/			Death (Check		6 □Other (Spe	ecify)
ion of	ding I. After fune	ation: T	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation		Bb. Time of Injury		lc. Injury a Work?	at es 2 □ No	28d. De	scribe how inj		
Division	o after	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory,	office			ation (Street a or Town, Sta		Rural Route Number,
	To the Hospitel within 24 hours of To the Funeral I completely filled	edical	29a. Certifier 1 Certifying Phy: (Check only 2 Medical Exami	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death n and/or in	n occurred a vestigation,	t the time in my opi	, date and p nion, death	place, and due occurred at the	to the cause(time, date ar	s) and manner a nd place, and du	s stated. e to the cause(s)
	To the within 2 To the complete	M	29b. Signature and title of certifier	1	2		License				ate signed (Mon	
2			30. Name and address of person who co			Print)			1 -			28, 2005
	Sta	ate	31. Date filed (Month, Day, Yeer)	13900 Baltim Registrar's Signatur			ıe;	Lau	rel, M	1D 207	υ /	
	Regist		DEC 3 0 2005	Stow A	And	2						

State of Maryland / Department of Health and Mental Hygiene 43560 Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) December 27, 2005 Physician 2:35 A M Helen Kay Thurtle /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Heritage Harbour Health & Rehab. Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Dec 31, 19 7. Age (In yrs, last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours 1 □ M 2 🛛 F 1938 Director 482-44-0270 66 Iowa Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or itema 23a or 28e-f ahow tre Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Howard Columbia Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21045 USA 6204 Wild Swan Way deeth v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 X Married Specify. White Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ρ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Education Teacher 4 Ith and Mental Hygis 27 is marked other i treumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 end 2 should be Agnes Korinne Gunderson Lindsey Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2 s Depertment of Heelth ar Important: if item 27 is any injury or other trau once. Terry O. Thurtle/husband 6204 Wild Swan Way Columbia, MD 21045 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 1 ☐ Burial 2XXX cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 28, 2005 Beltsville, Maryland 21. Signature of Funeral Service Ligenses Going Home Cremation Service P.O. Box 784 MO133/Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Renal Cell Carcinoma **Physician** /Medical Due to (or as a consequence of): Examiner Cerebrovascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires thet the deeth certificate be executed physicien end s the burial-transit c Parkinson's Disease Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attanding pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X☐ Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b firector, page 2 sl autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2XXNo ۵ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 XCartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 3 29d. Date signed (Month, Dev. Year) 29c. License number 29b. Signature and title at certifier D58683 December 27, 2005 Name and address of person who completed cause of death (Item 23a) (Type, Print) 344 W. University Blvd. #326 Silver Spring, MD 20901 Akoto, M.D. Richard Osei 32. Refistrar's Signature 31. Date filed (Month, Day, Year)
DEC 3 0 State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 15 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month / **Physician** 287 2005 ar Williams 7:15 A M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 7 L | Yre | Months | Days | Hours | Min. 8. Date of Birth 4/19/1931 9. Birthplace (State or Foreign **Funeral** 255-44-9894 1⊠M 2□F 74 Alabama Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Prince George's Bladensburg Director 10e, Street and Number 10f. Zin Code 10g. Citizen of What Country? 4202 58th #126 20710 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Item eny injury or other traumetic event, the Medical Examina 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 þ Specify: Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Gov't Truck Driver 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Williams John L. Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsie Thornton/Sister-in-Law 5602 Ellerbie St. 20706 Lanham, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 1/3/2005 Suitland, MD 21. Signatur of Furlaral Service 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between NEGATIVE SEPTICEMIA Onset and Death Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) SACRAL ULCER. Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Examiner the attending physician and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

— DIABETES MELLINS, SEVENE PERIPHERAL 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 3. No 3 Probably 4 Unknown Completed VASCINAL DISEASE, END STAGE RENAL DISEASE 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSION, MALNUTRINON. autopsy performed? PONO 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 EP/Outpatient 3 DOA 1 Yes PONO Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 12/28/200r D53367 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHYAM SUMMAR. RAJAN 10810, DARNESTOWN ROAD, SUITE: 202, GAITHERS BURG, MD: 20878. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State DEC 3 0 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene

For State Registrar 1. Decedent's Name (First, Middle, Last)

LULA MAY WELLER

Certificate of Death

Reg. No.

Dav

Vear

2005

2. Date of Death Month

DECEMBER 29

3. Time of Death

10:00PM^M

Physician
/Medical
Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "netural; or Items 23a or 28a-f show any njury or other treumatic event, the Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospitel or Attending Physiclen: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

					,,		of Death			4c. Coun	, 0, 004	1011	
	HADWICK	TERRACE				EAST					TA	LBOT	
5. Social Security 1 219-36-		3. Sex 1 □ M 2 F	7. Age (In yrs. 96	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of (Month) MAY	Birth Day,	Year) 1909	C	rthplace (State or Foreign ountry) RYLAND	
Usual Residence			1.0										
10a. State	10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits	
MD	TAL	BOT		E	ASTON							X Yes 2 □ No	
10e. Street and No	umber				10f. Zip Code				10	g. Citizen o	f What Co	ountry?	
111 CH	ADWICK T	ERRACE			21	1601					υ	JSA.	
11. Marital Status		12. Was Dec	edent Ever in U.	.S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Or	rigin? (Sp	ecify Yes o	No-	erican Indian,			
	ried 2. X Married 4. □ Divorced	d 1 ☐ Yes If Yes, Gi Year or D	i	1 ☐ Yes 2 No			rican, etc.	,	Black, White, etc. Specify: WHITE				
(0-)	15. Decedent's	16a. Deced	16a. Decedent's Usual Occupation (Give kind of work done during most of working						Business	s/Industry			
Elementary/Sec	ondary (0-12)	life. L	Kind of work done i DO NOT use retired	auring mos 1)	st of work								
12	511dary (5 12)	T	EACHER			1	ELEMEN	TARY	SCHOOL				
17. Father's Name	<u> </u>	w-1	18. Moth	er's Name		laiden Suma							
OSCAR S			NO	RA NO									
19a. Informant's N	Name/Relationship	19b. Mailir	ng Address (Street	and Numb	er or Rur	ımber.	City or Tow	n State	Zin Code)				
W. THO	MAS FOIIN	TAIN/PER	REP		. WASHING								
20a. Method of Dis			sition (Name of	or.,	-			Town, State					
1 Burial 2	Cremation 3	3 □Removal from		cemetery, cren	natory or other place	ce)				.oo. Loognor	i oity oi	Town, State	
	5 Other (Spe		WO		MEMORIAI			4/2006	5 📙	EASTO	N, M	IARYLAND	
21. Signature of F	ameral Service Li	censee So	nel	F	Name and Addre	ELFE	NBET	N & NI	WN/	M FUN	ERAL	HOME PA	
shock, or he Immediate Cause	art failure. List or (Final	omplications that only one cause on e	caused the deat	h. Do not ent	er the mode of dyin	ng, such as	cardiac o	ry arre	st,	Approximate Interval Between Onset and Death			
disease or conditi resulting in death	ion	_ a	(or as a conseq	ovar	of In	100	CTIC	m			Days		
		uence of):											
		ch.	11000	1-1	=:1.					V			
Sequentially list c	onditions,	b. — Dun to	conge		of In	FF	aile	ne				years	
Sequentially list of any, leading to i cause. Enter Und	onditions, mmediate lerlying		conge (or as a conseq		Hear	FF	āil	ne				years	
Cause (Disease of that initiated even	lerlying or injury ts	Due to		ruence of):	Hear	F	āili	ne				Years	
Cause (Disease o	lerlying or injury ts	Due to	(or as a conseq	ruence of):	Hear	F	aile	ne				Years	
Cause (Disease of that initiated even	lerlying or injury ts	Due to		ruence of):	Hear	F	aili	ne				Years	
cause. Enter Und Cause (Disease of that initiated even resulting in death)	lerlying or injury ts	CDue to	(or as a conseq	quence of):	Heor	F	āili	ne				Years	
Cause. Enter Und Cause (Disease o that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1	nerying rinjury ts Last nt pregnant 2 months?	Due to c	(or as a consequence of pregnation of pregnation of pregnation of the control of	nuence of): nuence of): ancy	Heov		Taile	ne			Pate of de	Yeory Day Year	
Cause. Enter Und Cause (Disease o that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1: 1 Yes 2 9 Unknow	nt pregnant 2 months?	C	(or as a consequence of pregnation to time of dispersions)	quence of): quence of): ancy al death 3 [leath 5 [Ectopic pregnancy	,			Did tob	N	Month	Day Year	
Cause. Enter Und Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1: 1 Yes 2 9 Unknow Part II. Other sign	nt pregnant 2 months?	Due to c	(or as a consequence of pregnation of pregnation of pregnation of the companion of the com	quence of): quence of): ancy al death 3 [leath 5 [∃Ectopic pregnancy	,		23e. [acco usa co	Month ntribute to	Day Year o the cause of death?	
Cause. Enter Und Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1: 1 Yes 2 9 Unknow Part II. Other sign	nt pregnant 2 months?	C	(or as a consequence of pregnation of pregnation of pregnation of the consequence of the	quence of): quence of): ancy al death 3 [leath 5 [Ectopic pregnancy	,		23e. [N	Month ntribute to	Day Year o the cause of death?	
Cause. Enter Und Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1: 1 Yes 2 9 Unknow Part II. Other sign	nt pregnant 2 months?	Due to c	(or as a consequence of pregnation of pregnation of pregnation of the consequence of the	quence of): quence of): ancy al death 3 [leath 5 [Ectopic pregnancy	,		23e. I	Vas ar	acco use co	ntribute to 3 Property Prior to death?	Day Year o the cause of death? robably 4 Unknown utopsy findings available completion of cause of	
Cause. Enter Und Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1: 1	nt pregnant 2 months?	Due to c	(or as a consequence of pregnation of pregnation of pregnation of the consequence of the	quence of): quence of): ancy al death 3 [leath 5 [Ectopic pregnancy	r en in Part l	1.	23e. [1 24a. \ a f	Vas ar utopsy enform	acco use co	ntribute to	Day Year of the cause of death? robably 4 XUnknown utopsy findings available completion of cause of	
Cause. Enter Und Cause (Disease o that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1: 1 Yes 2 9 Unknow Part II. Other sign	nt pregnant 2 months? Show	Due to c	tcome of pregnabirth 2 Feta nant at time of drown	ancy I death 3 leath 5 leath 5 leath 5 leath	Ectopic pregnancy Other (specify)	en in Part I	l. e of Deatl	23e. [1 24a. \(\) 24a. \(\) 1 \(\) Y. \(\) h (Check oil)	Vas ar utopsy enformes 2	acco use co s 2 \(\text{No}\) 24b	ontribute to 3 Property Prior to death?	Day Year of the cause of death? robably 4 Unknown utopsy findings available completion of cause of	
Cause. Enter Und Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1: 1	nt pregnant 2 months? Show the served to medical the served to me	Due to c	tcome of pregnabinth 2 Fetanant at time of down	quence of): quence of): ancy al death 3 [leath 5 [□Ectopic pregnancy □ Other (specify) nderlying cause giv	26. Place	I. e of Deatl	23e. [24a. v 1	Yes are utopsylectorm 29s 2	acco use co	Intribute to a prior to death? 1 Yes	Day Year of the cause of death? robably 4 Unknown utopsy findings available completion of cause of	
Cause. Enter Und Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1: 1	nt pregnant 2 months? In the pregnant 2 months 2 month	Due to c	tcome of pregnabirth 2 Feta nant at time of diown	uence of): uence of): ancy I death 3 [leath 5 [ulting in the unity of the unit	Ectopic pregnancy Other (specify) Inderlying cause give at 3 DOA Other 28c. Injur Wor	26. Place	I. e of Death	23e. [24a. v 1	Yes are utopsylectorm 29s 2	acco use co s 2 \(\text{No}\) 24b acco use co co s 2 \(\text{No}\) acco os 3 \(\text{No}\) ac	Intribute to a prior to death? 1 Yes	Day Year of the cause of death? robably 4 Unknown utopsy findings available completion of cause of	
Cause. Enter Und Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1: 1	nt pregnant 2 months? In the pregnant 2 months? No ificant condition Solution The predict of	Due to c	tcome of pregnabirth 2 Feta nant at time of drown	ancy al death 3 leath 5 leath	Ectopic pregnancy Other (specify) Inderlying cause give at 3 DOA Other 28c. Injur Wor	26. Place	e of Deathursing Ho	23e. [1 24a. v	Vas arutopsylerformuss 2	acco use co s 2 \(\text{No}\) led? Also winjury occur eet and Nun	Anonth 3 Pi 0. Were all prior to death? 1 Yes	Day Year of the cause of death? robably 4 Unknown utopsy findings available completion of cause of	
Cause. Enter Und Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1: 1	nt pregnant 2 months? In the pregnant 2 months? No ificant condition Solution The predict of	Due to c	tcome of pregnabinth 2 Fetanant at time of down	ancy al death 3 leath 5 leath	DEctopic pregnancy Other (specify) Indertying cause give at 3 DOA Oth 28c. Injur Wor M 1	26. Place	e of Deathursing Ho	23e. [1 24a. v	Vas arutopsylerformuss 2	acco use co s 2 \(\text{No} \) 24b 27 29 20 20 20 20 20 20 20 20 20 20 20 20 20	Anonth 3 Pi 0. Were all prior to death? 1 Yes	Day Year o the cause of death? robably 4 Unknown utopsy findings available completion of cause of s 25 No	
cause. Enter Und Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1: 1	nt pregnant 2 months? Last Int pregnant 2 months? No ificant condition S f o o o o o o o o o o o o o o o o o o	Due to c	tcome of pregnabinth 2 Feta nant at time of drown leath but not res gradient 2 of Injury of Injury oth, Day Year) e of Injury - At he ing, etc. (Specifi e best of my kno passis of examina	ancy aldeath 3 leath 5	DEctopic pregnancy Other (specify) Indertying cause give at 3 DOA Oth 28c. Injur Wor M 1	26. Place er: 4 \(\text{ No.} \) y at k? Yes 2 \(\text{ me. date ar.} \)	e of Death	23e. L 24a. V a f 1	Vas arutopsylerform as 2 Resider ibe ho Town	acco use co s 2 \(\text{No} \) 24b 24b 27b 29c 24b 27b 27c 27c 27c 27c 27c 27c 27	Anoth 3 Pi Were all prior to death? 1 Yes ther (Speurred	Day Year o the cause of death? robably 4 Unknown utopsy findings available completion of cause of s 25 No ecify)	
Cause. Enter Und Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1: 1	nt pregnant 2 months? I ast Int pregnant 2 months? I have a served to medical and investiga 6 Could no determin Certifying 2 Medical Experience of the served to medical and the served to medical a	Due to c	tcome of pregnabinth 2 Feta nant at time of down leath but not res graph of Injury and Injury - At he hing, etc. (Specification)	ancy aldeath 3 leath 5	Ectopic pregnancy Other (specify) Inderlying cause give at 3 DOA 28c. Injur Wor M 1 Deet, factory, office	26. Place er: 4 No. y at k? Yes 2 me, date ar	e of Death	23e. L 24a. V a f 1	Was arruvatops) enform as 2 mly one Resideribe horomore. Town, the came, da	acco use co s 2 \(\text{No} \) 24b 24b 26c 27c 28c 28c 29c 29c 29c 29c 29c 29	Abouth 3 Property of the prior to death? 1 Yes ther (Speurred	Day Year to the cause of death? robably 4 Unknown utopsy findings available completion of cause of s 2 No ecity) ural Route Number, s stated. e to the cause(s)	
cause. Enter Und Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was decede in the past 1: 1	nt pregnant 2 months? I ast Int pregnant 2 months? I have a served to medical and investiga 6 Could no determin Certifying 2 Medical Experience of the served to medical and the served to medical a	Due to c	tcome of pregnabinth 2 Feta nant at time of drown leath but not res gradient 2 of Injury of Injury oth, Day Year) e of Injury - At he ing, etc. (Specifi e best of my kno passis of examina	ancy aldeath 3 leath 5	Ectopic pregnancy Other (specify) Inderlying cause give at 3 DOA 28c. Injur Wor M 1 eet, factory, office In occurred at the fir vestigation, in my o	26. Place er: 4 No. y at k? Yes 2 me, date ar	e of Deathursing Ho	23e. L 24a. V a f 1	Was arruvatops) enform as 2 mly one Resideribe horomore. Town, the came, da	acco use co s 2 \(\text{No} \) 24b 24b 26c 27c 28c 29c 29c 29c 29c 29c 29c 29	Abouth 3 Property of the prior to death? 1 Yes ther (Speurred	Day Year o the cause of death? robably 4 Unknown utopsy findings available completion of cause of s 25 No ecify)	

DAMIAN SOOKLAL, 607 DUTCHMANS LAWE, EASTON MD, 21601

ORIGINAL

32. Registrar's Signature

State Registrar

31. Date filed (Month, Day, Year)

JAN 0 4 2006

				1 _ For	State of Ma	ırylan			f Health a of Death	nd Ment		うりりょ	7	4356	3
				Registrar			Cer	inicate t	Dealli	12.0	Rag.	No. U	<i>)</i>	3. Time of De	
	3	Physicia		1. Decedent's Name (First, Middle, Last, Alice S. Y	urwit	2					Month	Day 1	ear S	11:30	-
(/Medic Examin	_	4a. Facility Name (If not institution, give	street and number)			4b. City, Tow	m, or Location of	Death		4c. County of		,	
		× 4	\$60.0 <u>.</u>	Atlantic Genera	al Hosp,	,fa,	/	Ber	lin			Wor	ce	ster	
200m		Funeral Director		5. Social Security Number 6. Security Number 1579–10–6851	3.7	90 (In yrs. i	ast birthday) Yrs.	If Under 1 Y Months Da		Min. 8. D	eate of Birth Month, Day, Ye	1915	9. Birth Cou NEV	olace (State or F ntry) V YORK	oreign
20		p		Usual Residence of Decedent											
	_	ehow	_	10a. State 10b. County			, Town or Loc							10d. Inside City t 1 ☐ Yes 2	
1	١٥	after death with the Maryland or Iteme 23a or 28a-f ehow mirer mout be notified at	Funeral Director	DELAWARE SUSSEX		SE	LBYVIL								- NO
4	Ö	vith th	i	10e. Street and Number				10f. Zip Co			10g.	Citizen of Wh	nat Cou	ntry?	
7	Q	e 23a	ral	11 CLEVELAND AVE		Tues in 11	C 12.14		9975	in 2 (Consider)	Van an Na	USA 14. Race	Amari	ana fadina	
<u>o</u>	4		nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X N		3. 13. V	Yes, specify	of Hispanic Orig Cuban, Mexican,	Puerto Ricar	n, etc.)		White,		
-	99	rs aft	by F	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:	10	1	☐Yes 2🖔	No Specify:			Specify:	W	HITE	
4	49	72 hours after natural', or Ite	ed	15. Decedent's Edu	cation		16a. Deced	ent's Usual O	ccupation		160	. Kind of Busi	iness/Ir	dustry	
١	215	within 73 ena. then "n	Completed	(Specify only highest grad	e completed) College (1-4or 5	+)	(Give I life. D	kind of work d OO NOT use re	one during most stired)	of working					
5	212	giena giena er the	E O	12		.,	HO	OMEMAKE	ER			OWN F	IOME		
1	ק פ	be filed ital Hygi od other event, I	Be (17. Father's Name (First, Middle, Last)					18. Mother	's Name (Firs	st, Middle, Mai	den Sumame,)		
90	yan V		2	WILBERT S.	STI	LSON			J0	SEPHIN	E	FRA	NK		
g	Mary	C1 40 10 10	- 9	19a. Informant's Name/Relationship (T)					reet and Number						
	6)	s 1 and f Health Itam 27 other tr		ALAN W. YURWITZ/S	ON	20h B	LI (ND AVEN	UE, SE		LE, DE.			
	or			20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ F		0	emetery, crem	natory or other	place)						
	Baltimor	t. Pa rtmen rtant:		4 □ Donation 5 □ Other (Specify)		CR			LMARVA	1/2/0	6 DE	ELMAR,	DEL	AWARE	
S	Bal	permit. Page Department of Importent: If eny Injury or once.		21. Signature dt/Funeral Service Lidens	Van 1				ddress of Facility S FUNER		E, SELI	YVILLE	, D	E. 1997	5
20				23a. P intl. Enter the disease, or compleshock, or heart lailure. List only of	ications trut caused	the deatl	n. Do not ente	er the mode of	dying, such as c	cardiac or res	piratory arrest,			Approximate Interval Between	en
		Physician		Immediate Cause (Final disease or condition			onia						1	Inset and Dea	ath
1		/Medical		resulting in death)	Due to (or as									1.007.5	
9	*	Examiner		Sequentially list conditions,	b										
1		pe is	Examiner	il any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	à iconsuq	uence of):								
79		and -trans	каш		c. Due to (or as	2 000000	uanca of):						-		
S	8760,	Physician: The law requires that the death certificate be executed this cartificate has been signed by the attending physician and ral director, paga 2 should be detached for use as the burial-transit	Ical E		Dub 10 (01 a3 1	a conseq.	derice (1).								
•	687	phys phys s the			d								-		
7		laath certifical attending phy I for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregna	псу					23d. Date	of deliv	erv	
+	Вох	atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pregn Other (specif				Mont		Day Yea	ar
Srwit	P.O.	it the da by the tached	hysi	9 ☐ Unknown	9□ Unknown										
7		es that gned t	by P	Part II. Other significant conditions co	ntributing to death be	ut not res	ulting in the un	nderlying caus	e given in Part I.	1	23e. Did tobac	co use contrib	ute to t	he cause of dea	th?
-	rds	w requires been sign should be	b b	-Chronic obs	struction	1C_	puln	rona	y dis	sease	1 Yes	2 □ No 3	Pro	pably 4 □Unk	cnown
•	Records,	taw requas been 2 should	Completed	- luna mass			•		U		24a. Was an	24b. W	ere auto	opsy lindings ava	aılable
N		The tate has page 3	E	- Osemia							autopsy performed 1 ☐ Yes 2 ☑	1? de	ath?	mpletion of caus	se or
Se	Vital	cartifica ector, p	a	25. Was case reterred to medical					26. Place	ol Death (Chi		140	_ ,,,,	212310	
-		nysicia nis car direct	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Impatie	nt 2 🗆	ER/Outpatient	t 3 DOA	Other: 4 - Nur	rsing Home	5 Residence	e 6 □Other	(Speci	fy)	
Ŧ	n of	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year)	28b. Time of Injury	28c.	Injury at Work?		Describe how i				
	Sio	or:	catle	2 Accident investigation				М	1 Yes 2 N	40					
	Division	F 8 F C	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc	ury - At ho c. <i>(Specif</i>	ome, larm, stre y)	eet, lactory, of	fice	281. L	ocation (Stree City or Town, S	t and Number tate)	or Rur	al Route Numbe	1.
		To the Hospital c within 24 hours af To the Funeral D completely filled in	Ical C	(Check only 2 Medical Exami	sician: To the best of the basis of	examina	wledge, death tion and/or inv	occurred at ti	ne time, date and my opinion, death	d place, and d	due to the caus	e(s) and man and place, ar	ner as s	stated. o the cause(s)	
		thin 2 the the mplet	Med	one) 29b. Signature and title of certifier	and manner sta				cense number			Date signed			
1		F 3 F 8		> Kustine &	Jupe	2 1	10		-00067	00-1					
1		r1.D		30 Name and address of person who co	ompleted cause of d	eath (Iten	23a) (Type I	Print)							
	_	D NI		KRISTINE GRIA	FN, MI) (209	CUAST	AL HIE	SHWA	Y, FER	MICK	15	AND, D	E
		Sta Regist		31. Date liled (Month, Day, Year)	32. Pigistra	ar's Signa	iture	nous 1	,					199	144

		1	- State Amend #17, 1-	State of Ma 6-06, per	ryland FHDR	/ Depa HCH , Ce/	rtmen	t of H	ealth a	and M	lental Hy	giene	05	43564	
	• 35		Negistrar Necedent's Name (First, Middle, Last)								2. Date of Dea	ath		3. Time of Death	
	Physicia		Marciano Aguirre								Decembe	er 30,	2005	4:00 P M	
1 18	/Medic Examin	1411	4a. Facility Name (If not institution, give s	street and number)			4b. City,	Town, or	Location of	of Death		4c. Cour	nty of Death		
			Casey House					vill				Mont	gomery	7	
	Funeral Director		5. Social Security Number 6. Sec. 1X	7. Age	(In yrs. las		If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da Jun 5,	y, Year)	Cou	place (State or Foreign intry) entina	
	pud *		Usual Residence of Decedent 10a. State 10b. County	1	10c. City.	Town or Lo	cation							10d. Inside City Limits	
	Aaryla I sho	ō												1 ☐ Yes 2 No	
	28a-	Director	Maryland Montgomer	У	KOCK	ville	101. Zip	Code				10g. Citizen	of What Cou	intry?	
	3 with	Ö	13114 Superior Str	eet			208	353				USA			
	ms 2	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	. 13. \	Was Dece	dent of Hi	spanic Ori	Origin? (Specify Yes or No- ican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.					
396	72 hours after death with the Maryland natural; or items 23s or 28s-(show utes! Examiner must be molified at	by Fu	1 Never Married 2 Marned 3 Widowed 4 Divorced	1 Yes 2X N If Yes, Give Year or Dates:	lo		XXYes		Specify:		ntine		cify:Whit		
21215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grad			16a. Deced	dent's Usua kind of wo	al Occupa	ation <i>luri</i> n <i>a m</i> os	t of work	ina	16b. Kind of			
21	ithin ithin	npie	Elementary/Secondary (0-12)	College (1-4or 5		life. l	DO NOT u	se retired)			n /11	16		
2	ygier ygier her th	S	47 Fatharda Nama (First Middle Leat)	5+		Build	ing E	Engin		ar's Name	/First Middle			anagement	
Maryland	wold be fit Mental H arksd ott atic svsr	To Be	17. Father's Name (First, Middle, Last) Pedro Petro Aguirre						(unk	er's Name (First, Middle, Maiden Sumame)					
Man	permit. Pages 1 and 2 should be itled within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Depertment if item 27 is marked other than "natural", or items 23a or 28a-f ahow say finury or other traumatic avant, the Madical Examiner must be notified at ance.		19a. Informant's Name/Relationship (Type, Print) Olga Aguirre/wife 19b. Mailing Address (Street and Number or Rura 13114 Superior Street R												
ore,	es 1 a of Hea litsm rothe		1 Rurial 937 Cremation 3 Removal from State								nber	20c. Locatio	on - City or T	Town, State	
Ē	Page ment ant: if ury o		4 Donation 5 Other (Specify) Chesapeake Crematory 31											Maryland	
Baltimore,	permit. Depert Import sny Inj once.		21. Signature of Funeral Service Licens	40tt	MO12	Go 251 Be	ing l	nd Addres Home V L	crema Heck	ation rotte	n Servi	ce P. Clark	0. Box $sville$	x 7 84 e, MD 21029	
	* *		23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	ications that caused ne cause on each lin	the death.	Do not ent	er the mod	de of dyin	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition	. Cerebrov	ascu1	ar Ac	cide	nt						months	
	/Medical Examiner		resulting in death)	Due to (or as											
*		70	Sequentially list conditions, if any, leading to immediate	Due to (or as :	a consecue	ance offi:									
	ted nsit	in in	Cause (Disease or injury	·											
Ć,	execunand and al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):									
760,	ate be executed hysician and the burial-transit	cail		d											
99	tificat ig phy as th														
Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burtal-transit	Physiclan/Med	in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3[]Ectopic p] Other (s)						Date of deliment	very Day Year	
P.0	that the de ed by the detached	Phy	9 Unknown Part II. Other significant conditions co	atributing to doub by	ut not rocul	ting in the u	ndorhina	21150 224	on in Part I	-	23e Did t	nhacco use c	ontribute to	the cause of death?	
Records,	v requires that been signed should be de	þ	Septicemia, decubi			ung ar me u	indenying (cause givi	en in Fait			Yes 2 ∏XNo		obably 4 ∐Unknown	
ဝ၁	as be	Completed									24a. Was	osv	prior to c	topsy findings available completion of cause of	
Œ		mo.									1 Yes	rmed? 2X No	death?	2 No	
Vital	sicien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					1 04			h (Check only				
f	Physicien: r this certific ral director,	은	T Tes 2K No			P/Outpatier				ursing Ho	me 5 Resi			hospice	
n C	ding F h. After funer	o	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inju- (Month, Dat	y Year)	28b. Time o Injury	м	28c. Injur Wor	γαι k? Yes 2□	No	20d. Describe	now injury oc	cuired		
Division	or Attending efter death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be	28e. Place of Inju	ury - At hor	ne, farm, st							ımbər or Ru	ral Route Number,	
Ö	ે ફેંફેં ∈	erti	4 Homicide	building, et							City or To	wn, State)			
	To the Hospital or Attent within 24 hours effer death To the Funerel Director: completely filled in by the	Medical C		sician: To the best iner: On the basis of and manner sta	f examinati										
	vithin o the	Me	29b. Signature and title of certifier				29	c. Licens	e number			29d. Date sig	gned (Monti	n. Day, Year)	
	F>F0		· Chili la	fermal			D	4245	2			Decemb	er 30	, 2005	
1	ad		30. Name and address of person of Chitra Rajagopal N	ompleted cause of d	leath (Item	23a) (Type, aster	Print) Mill	Rd.	Rock	vill	e, MD 2	.0855			
7		ate	31. Date filed (Month, Day, Year)	32. Segistr	ar's Signati	ntė	-0								
	Regist	rar	JAN 0 3 20	Ub Bleev	as l	K A	and the	/							

t	•		1 - For State Registrar	State	of Maryl	land / Depa			lealth a Death			giene		5	435€	5
ı	Physici /Medic		1. Decedent's Name (First, Midd Jack N. Ander						-		2. Date of De Month December	Da		Year 2005	3. Time of 11:20	
	Examin		4a. Facility Name (If not institution	n, give street and n	umber)		1		Location	of Death		40	County	of Death		
			7810 Kachina 5. Social Security Number	Lane 6. Sex	7 Ann (In	see to at high day.		esda r 1 Year	If Under	24 Hrs	0.00.45		ontg	omer		
	Funeral Director		528-20-6909	1 XM 2 ☐ F	83	yrs. last birthday) Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da Oct. 19	ı <i>y, Yəar)</i>	922	9. Birthr	olace (State o ntry) iforni	r Foreign
	70		Usual Residence of Decedent				1				JCL. I	, <u>1</u>	722	Cai	TIOIHI	a
	Aaryla show	ō	10a. State 10b. County			:. City, Town or Lo	ocation							1	10d. Inside Ci 1 ☐ Yes	
	28a-	Director	Maryland Monte	omery	Ве	ethesda	10f. Zi	p Code				10a. Cit	tizen of \	What Cou	Λ	
	h with	IO IE	7810 Kachina	Lane			208				h	J.S.		viiat oou	,	
	r deat	by Funeral	11. Marital Status	12. Was De Armed F	cedent Ever forces?	in U.S. 13.			spanic Ori	igin? (Spec	cify Yes or No Rican, etc.))-		e - Americk, White,	can Indian,	
36	or It	y Fu	1 ☐ Never Married 2 ☑ Ma 3 ☐ Widowed 4 ☐ Divorce	rried 1 1 1 1 Yes If Yes, G Year or	2 No Rive WW		1 ☐ Yes		Specify:		, ,		Specify	,-		
9	2 hour	ted k	15. Decede	nt's Education		16a. Dece	dent's Usu	al Occupa	ation	100	-	16b. K	(ind of B	WII. usiness/In	ite	
215	thin 7.	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed College	(1-4or 5+)	(Give	kind of w DO NOT i	ork done d ise retired	during mos ')	it of workin	g			list	.,	
2	led wi lygien her th	Con	12	(4)		Synd	icate	d Co	1umni					Medi	a	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hyglene s marked other than "natural", or Items 23a or 28a-f show umatic event, the Modical Exacting must be notified at	o Be	17. Father's Name (First, Middle Orlando N. Ande								<i>(First, Middle</i> thman l			,		
ary Z	shoul ind Me i mark umati	2	19a. Informant's Name/Relation			19b. Maili	ng Addres				Route Numb				Code)	
Ž	and 2 salth a n 27 is er tra		Olivia F. Ander	son / Wif	e	7810	Kach	ina	Lane	Betl	nesda,	Mar	ylan	d 20	817	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: if Item 27 is marked other than "natural; or Items 23a or 28a-f show any Injuryage other traumatic event, the Medical Examination must be notified at any Injuryage.		20a. Method of Disposition 1₺ Burial 2 ☐ Cremation	3 □Removal fror		Ob. Place of Dispo cemetery, cre-	osition (Na matory or	me of other plac	a)	Dec.	23.	20c. L	ocation -	City or To	own, State	
<u>#</u>	rtmen rtant:		`4 ☐Donation 5 ☐ Other (I	Ferguson			1	2005	5	Roa	noke	, Vi:	rginia	
Ba	Depa Impo any i		Jely le my		Mac						eph Gar					20016
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Car	each line. diopul o (or as a con kinson	monary Ansequence of):	Arres		g, such as	cardiac or	respiratory a	rrest,			Approximate Interval Bett Onset and I	ween
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	·	nsequence of):										
.O. Box	that the death certific led by the attending p detached for use as	by Physician/Me	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2 🗍 I nant at time	Fetal death 3[∃Ectopic p ∃ Other (s						23d. Dat Mor	te of delive		'ear
S, D	quires that in signed b uld be deta		Part II. Dther significant condit	ions contributing to	death but not	t resulting in the u	nderlying	cause give	en in Part I			obacco (ne cause of do	
al Record		Completed									24a. Was auto perfo	osy irmed?	P	Were auto prior to con death?	psy findings ampletion of ca	available ause of
Vital	ysician: Th is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital	74	• C 50 10 1		Othe			Check onl					
ō	를 후 표	-	27. Manner of Death		Inpatient of Injury oth, Day Yea	2 ER/Outpatier 28b. Time o		28c. Injury Work	4 140		e 5 Resi				y)	
ion	Attending Isr death. ector: After by the funer	atlo	E C / tooldont	tigation	пп, шау төа	(Ir) Injury	М		r? Yes 2□	No						
Division of		Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	mined 289. Plac	e of Injury - a ding, etc. (Sp	At home, farm, stoecity)	eet, factor	y, office		28	Bf. Location (City or To			er or Rura	I Route Numi	ber,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier Certify (Crieck only one)	ing Physician: To the Examiner: On the and ma	ne best of my basis of exar nner stated.	knowledge, deat mination and/or in	h occurred vestigation	at the time, in my or	ie, date an pinion, dea	d place, ar th occurre	nd due to the d at the time,	cause(s date and	and mad place, a	inner as s and due to	tated. the cause(s)	
	With To 1	Σ	29b. Signature and title oncertifi	br 2	1		29	c. License				29d. Da	te signed	d (Month,	Day, Year)	
	5		Marino	Cullin	V Y	w)		1321	.3			Dece	mber	r 21,	2005	
			30. Name and address of person Michael L. W			(Item 20) (Type, 2021 K.		eet	N LI	Wash	instan	Л	c '	20006		
	Sta		31. Date filed (Month, Day, Year	7) 32	Registrar's S		eck		~1 e VV e	nasii	TIL COII	, Р.	0. 2	_0000		
	Registr	ar	DEC 2	9 2005		Jos pop	and a second									

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 26, 2005 **Physician** Willie James Allen 6:28 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery B. Date of Birth
(Month, Day, Year)
Sept. 12, 1920 North Carolina ff Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1X M 2 ☐ F 237-28-7123 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at X Yes 2 No Director Maryland | Prince George's Bladensburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "naturel", or iteme 23a or 5999 Emerson Street #427 20710 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after at Hygiane.

Other then "naturel", or ite 1 ☐ Yes 22€ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No þ 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Marriott Cooperation Consultant permit. Pages 1 and 2 should be filed w
Depertment of Heelth and Mental Hygiar
Important: It less 27 te marked other th
any Injury or other traumatic event, II and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Tom C. Allen Lula Virginia Walls 19a. Informant's Name/Relationship (Type, Print) ($ext{daughter})$ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia M. Allen-Mazique 6445 Luzon Ave. N.W., Washington, D.C. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Glenwood Cemetery 4 ☐Donation 5 ☐ Other (Specify) 12/30/05 Washington, D.C. 21. Signatore of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7400 Georgia Ave. N.W., Wash. D.C. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Provsician Septicemia 8 hours /Medical Due to (or as a consequence of): **Examiner** Pneumonia Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ettending physicien and for use es the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical *IF FEMALE:* 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of defivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2XXNo Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 | Yes 2 | No 3 | Probably 4\\ X\\ X\\ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 20 No 1 Yes 1 Tyes 2 No 25. Was case referred to medicaf examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔀 Inpatient 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA To the Hospital or Attending PP, within 24 hours after death.

To the Funerel Director: After if completely filled in by the funera 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MAS 2006/937 noluu L. Wiln 05 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

32. Jegistrar's Signature

CANDACE L. WILSON, MD - 1500 FOREST GLEN RD SILVER SPRING, MD 20910

			For State Registrar	State of Ma	aryland /		rtment of H		f Mental Hyg	giene Reg. No.	005	3567	
	Physicia	an	1. Decedent's Name (First, Middle, Las	ta B. Ar	rn		2. Date of Dea						
)	/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death Dayton				4c.	County of Death			
	uneral irector		5. Social Security Number 215-01-0350 6. Se	99	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		^h 28),	1906°u	place (State or Foreign ntry) MD		
ryland	Pages 1 and 2 should be little the within 12 ment of Health and Mental Hygiene. ant: if item 27 is marked other than "na ury or other treumatic event, it is Medical in the		Usual Residence of Decedent 10a. State 10b. County		10c. City, To							10d. Inside City Limits	
with the Ma		Director	MD Linthicum 1 \square Yes 2 \square No 10e. Street and Number 454 Gayle Dr. 21090 USA										
Je Je		by Funeral	11. Marilal Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedeni Armed Forces? 1 Yes 2XIII If Yes, Give Year or Dates:		1		ispanic Origin?	(Specify Yes or No- ento Rican, etc.)		14. Race - Ameri Black, White, Specify: Wh		
d 21215-UU36 filed within 72 hours af Hypiene		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			(Give life. [lent's Usual Occup kind of work done o DO NOT use retired ecretar	during most of w l)	vorking	16b. Kind of Business/Industry hospita1			
2 2 3		Be	17. Father's Name (First, Middle, Last)	liam W.	Brand			18. Mother's N	lame (First, Middle, May Gre			Car	
Mary		7	19a. Informant's Name/Relationship (7 Shirley Murphy				•		Rural Route Numbe			,	
Pages			20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other Specify		ceme	tery, cren	sition (Name of natory or other place urg Cres	matory	Date		cation - City or To nithsbu		
Decrinit.			21. Signature of Funeral Service Licen						mpson Fi				
Physician /Medical Examiner		ner	23a. Part I Effer the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc, or heart failure. List only one cause on each ine. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
8/6U, cate be executed	in a raw requires that the beath cerminate has been signed by the attending page 2 should be detached for use as	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	Due to (or as a consequence of):								
. BOX 6		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 20 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea		Ectopic pregnancy			2	23d. Date of deliv Month	ery Day Year	
rds, P.		by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did to								acco use contribute to the cause of death?		
I Hecords, The law requires t		Completed	Alpheimers disease 24a							an sy rmed? 2 2 No	24b. Were autopsy findings available prior to completion of cause of death? No 1 1 Yes 2 No		
on of Vital		To Be	25. Was case referred to medical examiner? 1								(y)		
DIVISION el or Attending		Certification:	3 Suicide 6 Could not be determined	farm, str	eet, factory, office		28f. Location (S City or Tox	(Street and Number or Rural Route Number, wn, State)					
the Hospita		edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
Tot		Σ	29b. Signature and title excertifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)										
1		Robert W Olwine wid (15 1005/er Rd Glen Barnie MD 21060									1060		
	Sta Registr	ar	JAN 0 4 20		rar's Signature	for	uli .						

The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, peen has certificate this After thi

State of Maryland / Department of Health and Mental Hygiene 15 Amend Item 20b Per FH g852 9969 Ref Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year RAYMOND N/M/N BANKS DECEMBER 17,2005 12:19**P**M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 11370 DAYS COURT, RM#119 WALDORF CHARLES If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) DEC. 15, 1942 Birthplace (State or Foreign Country)
 NEW YORK 7. Age (In yrs. last birthday) **Funeral** 1 💢 M 2 🗆 F 63 Yrs. Director 103-32-6984 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MARYLAND CHARLES 1 ☐ Yes 2 ☑ No Directo WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 0 6 0 2

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11370 DAYS COURT **ROOM 119** 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 247 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🏋 No Specify: WHITE Specify: Completed by 3 Widowed . 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 SALESMAN WALDORF FORD AUTOMOTIVE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked UNKNOWN 2 UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i JAMES T. NORVELL-FRIEND 7017 OAK GLEN DR., HUGHESVILLE, MD 20637 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if ite any injury or ot once. 1/25/2006 1 ☐ Burial XXCremation 3 ☐ Removal from State METROPOLITIAN CREMATORY UNKNOWN ALEXANDRIA, VA * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MO0479 RAYMOND FUNERAL SERVICE, P.A. Micho 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as carried by pirality are it, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Schemic Heart /Medical ue to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Na Residence 6 Other (Specify) 1₽Yes 2□ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No М investigation 2 Accident Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Wha 12.23.2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20646 W. NESup 01 La pluta MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 1 8 2006 1300 Registrar

PM 5-08759 ary Bragunier

Baltimore, Maryland 21215-0036

Unpend item#23a,PII,27,28a-f, pen/e,685,1/19/06 IT

State of Maryland / Department of Health and Mental Hygiene | 15 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death December 26, 2005 **Physician** 11:50 Gary Van Bragunier /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2312 Ewing Avenue Unit #12 Suitland Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yes 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□ F Yrs Director Mar 16, Maryland 578-76-1890 48 1957 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County r than "naturel", or items 23s or 28s-f ehow the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Prince George's Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20746 2312 Ewing Avenue Unit #13 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2X No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Painting Painter nd 2 should be filed all and Mental Hygid 27 le marked other r traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Peges 1 and 2 should be Depertment of Heelth and Mental Importent: if item 27 ie marked c eny injury or other traumatic eve singerial. George Daniel Bragunier Agnes Dallas White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Calvin Bragunier/brother 4891 Anna Simpson Road Milton, FL 32583 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State December 1 ☐ Burial 2 【☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 31, 2005 Beltsville, Maryland 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 My L. He 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** Alcohol Intoxication complicated by Hypothermia /Medical Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physicien: The law requires that the death certificate be executed physicien and the burial-trensit Due to (or as a consequence of): Physician/Medical use es the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9□ Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cirrhosis of the Liver 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗡 Unknown

page 2 should hes this certificate director funeral deeth. of the deeth the

Be

Certification;

Medical

filled in by

cumpletely

Division of Vital Records, P.O. Box 68760,

autopsy performed? 1 XYes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of 1 ∠ Yes 2 □ No

25. Was case referred to medical examiner? examiner? 1XXYes 2 □ No

3 Suicide

29a. Certifier

4 | Homicide

27. Manner of Death 1 Naturat
2 Accident

5 Pending investigation 6 Could not be determined

H

Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 12/26/05

ma

28a. Date of Injury Find (Month, Day Year) 28b. Time of Find 28c. Injury at Injury

1 ☐ Yes 200 No

26. Place of Death Check only one

Other: 4 Nursing Home 5 Residence 64 Other (Specify) SCENE 28d. Describe how injury occurred Exposure to low

10:00 A Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify)

Found outside residence

environmental temperature 28f. Location (Street and Number of Rural Route Number, City or Town, State) 2312 Ewing Ave.

Suitland, MD

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

> 29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year)

lauma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Perm Street, Baltimore, Maryland 21201

December 27, 2005

100 State

To the Hospital within 24 hours e To the Funerei D

31. Date filed (Month, Day, Year) JAN 03 2006 Registrar

Me

29b. Signature and title of certifier



			For State Registrar		State of I	Maryland		artment of He rtificate of D		nd M		jiene	05	43570	
			1. Decedent's Name (First, Mide			2. Date of Dea Month	th Day	3. Time of Death							
	Physicia /Medic		Webster Butler							I	ecember		Year 2005	8:12AM M	
	Examin		4a. Facility Name (If not institution		4b. City, Town, or I	Death		4c. County of Death							
			26448 Mason Webster Road					Princess Anne				Somerset			
	Funeral Director		5. Social Security Number 220-68-8024	7. Age (In yrs. last birthday) 47 Yrs.		If Under 1 Year If Under 24 Hrs. Months Days Hours Min.			8. Date of Birth (Month, Day, Year) 10/30/1958		9. Birthplace (State or Foreign Country) Virginia				
	pur M	}	Usual Residence of Decedent 10a. State 10b. Count	v		10c City	Town or Lo	ecation						10d. Inside City Limits	
	laho ed a	ō												1 Tes 2 No	
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heelth and Mentel Hyglene. Important: if item 27 ie marked other than "natural", or iteme 23a or 28a-f show important: if item 27 ie marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Exertified Exertified all ADICA.	rect	MD Somerset Princes 10e. Street and Number					S Anne			Og. Citize	Citizen of What Country?			
		Funeral Director	26448 Mason W	ebst	er Road			2185	3		J	USA			
		nera	11. Marital Status	11. Marital Status 12. Was Decedent Eve Armed Forces?.				Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R			cify Yes or No-	14	. Race - Amei		
36	rs after I', or Ite	by Fu	1 Never Married 2 Ma	1	1 Tes 2 If Yes, Give Year or Date	No		1 □ Yes 2 No	Specify:	, Puerto r	rican, etc.)	s	Black, White		
215-0036	tura	ted	15. Decede	ation		16a. Dece	dent's Usual Occupa	16b.		White Kind of Business/Industry					
215	within 72 ene. than "na	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)					ive kind of work done during most of working e. DO NOT use retired)							
21	giene giene gr the	E O	10		none		Mercha	ant Seamar	1			Trans	sport (Company	
	be filed itel Hygi of other event, I	Be (17. Father's Name (First, Middle				13.4		18. Mother	r's Name	(First, Middle,	Maiden S	umame)	•	
<u>yla</u>	should k nd Ment marked umatic	2	Joseph Emory Butler Inez Webst												
Maryland	2 sho and ie m	o: H	19a. Informant's Name/Relation Inez W. Butler					ng Address (Street a Mason We				-			
	1 and Health em 27 ther t		20a. Method of Disposition	/ FIO C		20b. Pla		sition (Name of	DSCEI		ate		ation - City or		
Jor	permit. Pages 1 Depertment of H Important: if ite any injury or ot once.		1 🗆 Burial 2000 Cremation		emoval from St	ate ce	metery, crei	natory or other place	· 1						
Baltimore,	ortme ortani injury		4 □ Donation 5 □ Other		6	Sali	(C) Colombia	Cremator		2/28		salls	bury,	Maryland	
Ba	Deperminant important important in any ir sonce.	U	MININ L		1 N NO			Name and Address inman Fun							
			MD 21853 238 Part1. Enter the liser e, ir complications that used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between												
	Physician	1	Immediate Cause (Final	st only on	e cause Dead	line.	. M	elein						Interval Between Onset and Death	
	/Medical Examiner	U	disease or condition resulting in death)	a	Due to (or	a conseque	ence of):	Recons					-	1 year	
	D #	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):													
	icate be executed physician and s the buriai-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a consequence of):										
60,		Ē	rosaming in doubly East		Due to (or	as a conseque	; a consequence or):								
68760,		dicai		d	d										
			IF FEMALE: 23b. Was decedent pregnant	23	3c. If yes, outco	me of pregnan	icy					22	d. Date of deli	NAD.	
Вох	aw requires that the deas been signed by the and should be detached	Physician/M	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death 5 Other						ctopic pregnancy Other (specify)			Month		Day Year	
0		hysi	9 Unknown		9□ Unknow	m		, ,							
σ,		by P	Part II. Other significant continuous continuum dio death out not resulting in the underlying cause given in Part I.							23e. Did to	23e. Did tobacco use contribute to the cause of death?				
rd										1 ☐ Yes 2 No 3 ☐ Probably 4 [obably 4 Unknown		
Records,		Completed									24a. Was a	ın	24b. Were au	topsy findings available completion of cause of	
Œ.	0 4 0	mo.									perfor	enormed? death?			
Vital	Physicien: The this certificate ral director, pag	Be (25. Was case referred to medic examiner?	<u> </u>							(Check only &	10)			
of V	d is	2	1 Tes No	H	ospital: 1 ☐ Inp		R/Outpatier		r: 4 🗆 Nur				Other (Spec	eify)	
n	ng fter	on:	My er o Death Natural 5 ☐ Pend		28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?						8d. escribe h	ow injury	occurred		
Division	To the Hospitel or Attending within 24 hours effer death. To the Funerel Director: After completely filled in by the fune	icat	2 Accident invest	tigation d not be				M 1 Yes 2 No			28f. Location (Street and Number or Rural Route Numb			ant Courts Many has	
		ertification:	4 Homicide dete	28e. Place of Injury - At home, farm, s building, etc. (Specify)			reet, factory, office 28f.			City or Town, State)					
		Saic	29a. Certifier Certify	ing Phys	ician: To the b	est of my know	vledge, deat	h occurred at the time	e, date and	d place, a	nd due to the o	ause(s) a	nd manner as	stated.	
		ledicai													
	With To COT	Σ	29b. Signature and title of certif	ier /	2/	/)	Λ	29c. License	_	70		9d. Date	signed (Month	n, Day, Year)	
		15	WU ?		1	M	1/7	02	60	1/8		10	7-46	1-05	
30. Name and address of person who completed cause of peath (Item 23a) (Type, Print) Doi A E Core MO Cost Hospin 10 Box 733 Solish MD 2 State 31. Date filed (Month, Day, Year) 32. Egistrar's Signature 32. Egistrar's Signature MDEC 3 0 2005 March 15 February MDD 2 State Registrar DEC 3 0 2005 March 15 February MDD 2 State DEC 3 0 2005 MDD 2 MDD 2 MDD 3 MDD										21800	5-05				
	Sta	ite:	31. Date filed (Month, Day, Yea	1)	32.	gistrar's Signati	ure .	<i></i>			() 100k	J	1,000		
	Regist	rar	DEC 3	U 20	15 16	was s	J. /	perce							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 44/AM Month Year **Physician** JAMES BRAKEFIELD DEC 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mariner Healthcare of Greater Laurel Laurel Prince George 's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 30, 1927 7. Age (In yrs. last birthday) 78 Yrs. 9. Birthplace (State or Foreign Country)
South Carolina **Funeral** 250-24-0342 **™** 2□ F Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f show r then "netural", or items 23e or 28e-f shov the Medical Examinar must be notified at Maryland Prince George's Beltsville 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3903 Foreston Road 20705 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No White Specify: ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Water Meter Cut-off District Water Dept. permit, Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 Is marked other th any injust beaugher treumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harold Hope Brakefield Alice Irene Woods 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3903 Foreston Road Beltsville, Maryland 20705 Jean M. Brakefield -wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 1/4/2006 Alexandria, Virginia * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Eugeral Service Licensee Bonaid V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Intracerebral Hemorrhage Physician 4 weeks /Medical Due to (or as a consequence of): Examiner Hypertensive Heart Disease 5 years Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Day Year 5 Other (specify) 9☐ Unknown 9 ☐ Unknown signed by t d be detach Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 No 1 ☐ Yes or Attending Physicien: funeral director, Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 ANatural 5 Pending investigation death. M 1 Yes 2 No 2 Accident To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

31. Date filed (Month, Day, Year)
DEC 3 0

29b. Signature and title of certifier

2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

B.G. Manejwala, M.D. 14201 Laurel Park Drive Laurel, Maryland 20707

29c. License number

D13671

29d. Date signed (Month, Day, Year)

December 28, 2005

Maryland 21215-0036

Baltimore,

Box 68760,

P.O. –

Division of Vital Records,

Amend # 16B & 16A per F.D. 12-30-05 A.A.Co. Health Dept. PM Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 10:00AM December 27, 2005 inginia /Medical 4c. County of Death 4a, Facility Name (If not institution, sine street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 29 9. Birthplace (State or Foreign Country) W. Virginia 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1918 W. **Funeral** Days Hours 1 M 2 K Months 87 Yrs. 236-26-4464 Jan Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Maryland Anne Arundel Annapolis Direct 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 20 Washington Dr. 21401 USA items 23a death 1 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after dea Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "natural! or in-any injury or other traumatic averages. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2X No Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify. **Black** Specify: If Yes, Give Year or Dates: ģ 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) H ospital Nurse 12th n 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Barber Ulessie Cozart 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ruby Simms(Sister) 900 Nicholson St. Annapolis, Md. 21401 20b. Place of Disposition (Name of Hicameter) (Spendage for other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Gardens 12-30-05 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Wm. Reese & Sons Mortuary, P.A. Moo 482 Wm. Reese & John Md. 821 West St. Annapolis, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Vrhythmic /Medical Due to (or as a consequence of) heart disase Examiner Buten 516 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine ed by the attending physicien and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 the death certificate be Physician/Medical IF FEMALE If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ate has been signed by t page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy No 1 Yes 25 No Hospital or Attending Physician: 25. Was case referred to medical After this certific funeral director. 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death Injury at Work? 1 Natural 5 Pending after death. Director: Aft М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funeral C 274 Cartflet Certifying Physician: To the best of my knowledge, death occurred at the time, date and plane, and due to the nause(s) and manner as stated Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the e 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2003 Modical Partury Sude NU Auropolis State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0 **Physician** Doone 2005 inlei December 12:18 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death City, Town, or Location of Death Examiner linton Mariland Prince Louthern benges If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 9. Sex 1 M,M 2 ☐ F 7 Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days 49 Yrs. 579.76-6414 telrax Director Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits worke th and Mental Hygiene. If ie marked other than "natural", or Items 23e or 28e-1 ehov traumatic event, the Medical Examinar must be notified at 1 Yes 2 No MC vital Iteights Director trince 10e. Street and Number of. Zip Code 10g. Citizen of What Country? 20743 4308 neted LOYQUE Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 th No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Black Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BEI Ruck 8th DRIVER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 end 2 should be unk Peter Doone. arrie ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Captal Heights MD 20743 f Health if Torque St vanita Boone 4308 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: if Ite any Injury or ot once. cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Boone Welden 4 □ Donation 5 □ Other (Specify) tamuld Cemeter DI 150 DOCK Khines Funeral Home Facility John Ignature Funeral Service Icensee 22. ame and Address 1. ME Street, Washington DC 20017 a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final In Know N **Physician** disease or condition resulting in death) /Medical Due to (or as a consequ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury iEnow Examine physicien and s the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending for use as 25 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Ducknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed certificete 1 ☐ Yes 20110 Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 2 1 HB 1 / Impatient 2 ER/Outpatient 3 DOA his 28a. Date of Injury (Month, Day Year) After thi 27. Manner & Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No teral Director: A deeth. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours after To the Funeral Dire 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number December, 23,05 04 o completed cause of death (Item 23a) (Type, Print) and address of per

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day)

Year)

3 2006

2. Registrar's Signature

			1 _ State	State of Maryland / Depa	artment of Health and M	Con	, UUU 90017
			Registrar 1. Decedent's Name (First, Middle, Last)	06	Tillicate of Death	Reg. N	3. Time of Death
	Physicia	an		4.4			^{Year} 25, 2005 11:00A ^M
,	/Medic Examin		Ivaline L. Barre 4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death		c. County of Death
	Examin	er	Bowie Health Care		Bowie	I	Prince George's
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		213-34-9230	M 20 XF 70 Yrs.	Montale Bayo House	09/08/1935	Maryland
	pu 🔉	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	sho	ō					X⊠Yes 2 No
	the N	Directo	Maryland Prince Ge	orge s bowle	10f. Zip Code	10g. C	Citizen of What Country?
	with	ā	3850 Enfield Chase	C+ #110	20716		J.S.A.
	ms 23	Funerai			Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerti		14. Race - American Indian,
ယ	or Iter	표	1 ☐ Never Married 2 Married	1 ☐ Yes 2 🖾 No	1 Yes, specify Cuban, Mexican, Puent	o Rican, etc.)	Black, White, etc.
ဇ္ဇ	ral', c	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	TE THE ZEE INC. Specify.		Specify: White
5	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28e-f show the Madicel Examinat must be motified at	Completed	15. Decedent's Educ (Specify only highest grade	(Give	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king 16b.	Kind of Business/Industry
121	within	m du	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	3	Marriot Inc.
2	Hygie ther t	e Co	12 17. Father's Name (First, Middle, Last)	Chef	18. Mother's Nan	ne (First, Middle, Maide	
an	d be ental red o	8			Marry Toy	uias Chart	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28e-f show any injury or other traumatic event, the Marical Examinat must be notified at once.	မှ	Bernard Wilson 19a. Informant's Name/Relationship (Type	oe, Print) 19b. Mail	ing Address (Street and Number or Ru	uise Short _{Iral Route Number, City}	or Town, State, Zip Code)
Ž	nd 2 alth a 27 is		William Barrett/H	usband 3850	Enfield Chase Ct.	Bowie, MD	20716
Baltimore,	of Height		20a. Method of Disposition	20b. Place of Disp	osition (Name of matory or other place)	Date 20c.	Location - City or Town, State
E	Page nent c int: If		1A Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)		coln Cemetery 12/	31/2005 B ₁	centwood, MD
alti	permit. Departn Imports any inju		21. Signature of Funeral Service License		-11.		Funeral Home
<u> </u>	89 = 9		· Whh!	1000	401 Bladensburg Ro	d. Brentwoo	od, MD 20722
н			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death. Do not en ne cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Fatal Cardiac Ar	rhythmia		
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):			
١.	Examiner	_		Due to (or as a consequence of):	ease		
•	led nsit	Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Hypertension			
_6	death certificate be executed e attending physician and of for use as the burial-transit	xar		Due to (or as a consequence of):			
760,	ate be e nysiclar he buri	ical	L.	1			
687	ificate g phys as the						
Вох	leath certifical attending phy ifor use as th	Physician/Med	23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery
	deat	sicia	in the past 12 months? 1 □ Yes ②□XNo		Other (specify)		Month Day Year
P.0	The law requires that the de ste has been signed by the a bage 2 should be detached t	Phys	9 Unknown		A A S A S A S A S A S A S A S A S A S A	22a Did tabasa	o use contribute to the cause of death?
	es tha igned be de	by	The state of the s	ntributing to death but not resulting in the Breast Cancer	underlying cause given in Part I.	1 ☐ Yes	
Records,	w requir been si should	Completed	HISCOLY OF	breast dancer		1	
ec	has by	npie				24a. Was an autopsy performe <u>d</u>	24b. Were autopsy findings available prior to completion of cause of death?
= H	The cate h	Sol				1 ☐ Yes 2 🗗	No 1 ☐ Yes 2 ☐ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Other -	ath (Check only one)	
of	Physical this all dir	٠. ا	1 Yes 2 No	1 ☐ Inpatient 2 ☐ ER/Outpatien 28a. Date of Injury 28b. Time	ant 3L DOA 4 2 Nursing F	lome 5 Residence 28d. Describe how in	
	Jing I	tion	1 Natural 5 Pending	(Month, Day Year) Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		,-,
is:	or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, s	treet, factory, office		and Number or Rural Route Number,
Division	after after I Direct	Certification;	4 Homicide	building, etc. (Specify)		City or Town, St	ate <i>j</i>
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge, dea	ith occurred at the time, date and place	e, and due to the cause	o(s) and manner as stated.
	n 24 l n 24 l ne Fu	edical	(Check only 2 Medical Exami one)	ner: On the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occi		
	To the To the Comp	M	29b. Signature and title of certifier	0	29c. License number		Date signed (Month, Day, Year)
			1 Sund	- MD	D48152	12	2/30/01-
10	(5)			ompleto cause of death (Item 23a) (Type	e, Print)	1	1 200016
1				4, MD 1221 Mei	cantile lane,	Largo, MI	1 20174
	St Regist	ate	31. Date filed (Month, Day, Year) JAN 0.3 2006	1. Registrar's Signature	uli		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1/3/06 mp Operation of Health and Mental Hygiene (1- State Registrar Amend item 31 per H.D. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Ruth Alice Battaglia December 28, 2005 6:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Waldorf Healthcare Center Waldorf Charles If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 New York **Funeral** 1□M 2XF Yrs. 084-18-7170 84 16, Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iteme 23a or 28a-f ehow any Injury or other treumatic event, the Medical Examiner must be notified at once. 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Completed by Funeral Director Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3107 Tudor Road U.S.A. 20601 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Receptionist Steel Fabrication 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jesse McNutt 2 Alice Calvert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3107 Tudor Road, Waldorf, Maryland, 20601 James L. Battaglia / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Lawn 01-05-2006 4 ☐ Donation 5 ☐ Other (Specify) Akron, New York 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01246 P.O. Box 156 A Willy Vack Huntt Funeral Home Waldorf, Maryland 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Renal Failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, feeding to immediate cause. Enter Underlying Cause (Disease or injury Examiner Dua to (or as a consequence of): attending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 10 that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ been signe should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No certificete 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 | Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation within 24 hours after death. To the Funerel Director: A 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0057999 12/29/05 MANISHA JARINAZA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11637 Tennace Duine Ste 102 Ste 103. Waldouf, MD, 20602 lerrace Drive 32. Registrar Signature 31. Date filed (Month, Day, Year) State 2006

Registrar

			For State Registrar	State of Ma	aryland /		artment rtificate			nd Me		iene) 0 5)	357	6
7	Dhysiai	20	Decedent's Name (First, Middle, Last		_						Date of Deat Month_		∕e <u>a</u> r	3. Time of I	
	Physici: /Medic		Michael Lawrence		•						ecember			12:50	a M
ar .	Examin	er	4a. Facility Name (If not institution, give				4b. City, To			Death		4c. County of			
- 82	- F % -		Maplewood Park Pl 5. Social Security Number 6. Se		e (In yrs. last b	irthdav)		thesda Year If		4 Hrs. g	Date of Birth	Montgo			Foreign
	Funeral Director			M 2□F	84	Yrs.	Months	Days H	Hours	Min.	(Month, Day, July 8,			place (State or ntry) liana	
	ס		Usuat Residence of Decedent												
	arylar ehow	-	10a. State 10b. County Maryland Montgome	rv	10c. City, To	wn or Lo thes								10d. tnside Cit 1 ☐ Yes	
	he Ma	ecto						No. of a		-	1	0g. Citizen of Wh	Lat Cour		
	with t	D.	10e. Street and Number (Maple 9707 Old Georgetow			,	10f. Zip C	20814			'	3	sa cou	illiy :	
	leeth ns 23	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S.	13. 1	Was Decede	nt of Hispa	nic Origi	n? (Specif	y Yes or No-	14. Race	- Ameri	can Indian,	
9	within 72 hours after deeth with the Maryland ene. then "netural", or items 23e or 28a-f ehow the Modical Exercities from the notified at		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ I	No WWI	-	f Yes, specif 1 ☐ Yes 2	•	Mexican, Specify:	Puerto Rio	can, etc.)	Specify:	White,		
8	ours a	d by	3XXWidowed 4 □ Divorced	If Yes, Give Year or Dates:			10 105 21	<u></u>	эрөспу.			Бреспу:			
2	n 72 h	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	16	(Give	dent's Usual kind of work DO NOT use	done durii	n ng most d	of working		16b. Kind of Bus	iness/in	idustry	
12	withir ene. then	Juno	Etementary/Secondary (0-12)	Cotlege (1-4or 5	5+)		ecommi		tion	S		State De	epar	tment	
<u>5</u>	illed Hygi other	Be Co	17. Father's Name (First, Middle, Last)					18	. Mother	s Name (/		Maiden Sumame,			
lan	uld be Aenta rked ric ev	To B	Michael L. Burke						Cori	nne I	Luichin	ger			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "netural", or items 23a or 28a-1 ehow any injury or other traumatic event, the Medical Exposiner mast be notified an once.		19a. Informant's Name/Relationship (T)	ype, Print)	15	b. Mailir	ng Address (Street and	Number	or Rural P	Route Number	, City or Town, S	tate, Zij	code)	
	and lealth m 27 her tr		Michael L. Burke	, Jr./ Sc			Fenin		Road	, Whe		Maryland			
20	it of F		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I		cemet	егу, сгег	natory or oth	er place)	De		er 30		•		1 d
Baltimore,	it Pa intmer injury		4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens		Gate		eaven Ce	-	-			ilver Sp Home In		ig, Mar	yrand
Ba	Depar Impor		Annemal	exterl	u	5	00 Uni	lvers.	ity :	Blvd,	W, Si	lver Sp			
g- 18			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	licătions that caused ne cause on each li	d the death. Do	o not ent	er the mode	of dying, s	uch as ca	ardiac or r	espiratory arr	est,		Approximate Interval Betwoonset and D	/een
A (2)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a_Respira			re								
	Examiner				a consequenc	e of):									
	* *	ler	Sequentially list conditions, in the list conditions, cause. Enter Underlying	b. Pneumon	a consequence	a of):									
	cate be executed obysicien and the burial-transit	Examiner	that initiated events	c.											
Ö,	e exe ien ar urial-t	Ex	resulting in death) Last	Due to (or as	a consequenc	e of):									
8760,	ate b	dica		d											
9	eath certific ettending pl for use as t	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy							23d. Date	-4 -4-1b-		
Вох	death certificate be executed e ettending physicien and od for use as the burial-transit	Physician/Medical	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetat dea		Ectopic pre					Mont		-	ear
o.	that the de led by the e detached i	isku	1 U Yes 2 No 9 Unknown	9□ Unknown				- //							
ر. م	law requires that the as been signed by th 2 should be detache	by PI	Part II. Other significant conditions co	-	-			-	n Part I.		23e. Did tol	pacco use contrib	oute to t	the cause of de	eath?
ğ	w require been sig should b	edt	Coronary Artery D)isease, 1	umbar	Disc	Disea	ase,			1 □ Ye	es 2 ⊠ No 3	Pro	bably 4 □U	nknown
Vital Records,	elawre hasbe ge 2 sho	Completed	Chronic Back Pair	1						_	24a. Was a autops			opsy findings a	
E	E 5 %	Con									perform 1 ☐ Yes :	ned? de	ath?	2□ No	
Vita	ticlan: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othor			Check only on				
	S S	P.	1 Yes 2 No 27. Manner of Death	1 Inpation		Outpatier . Time o						ence 6 Other		fy)	
ou	ding h. After fune	tion	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da		Injury	м	c. tnjury at Work? 1 Yes	2 🗆 N			,	-		
Division of	Attending r deeth.	ifica	3 Suicide 6 Could not be determined	286. Place of In		farm, sti	reet, factory,	office		28		reet and Number	r or Run	al Route Numb	oer,
á	s effe	Certification:	4 Hollicide	building, et	c. (Specify)						City or Town	1, 3(2(9)			
	To the Hospital or Attending Ph within 24 hours effer deeth. To the Funeral Director: After thi completely filled in by the funeral	edical ((Check only one)	iner: On the basis of and manner st	f examination i	ge deat and/or in	vestigation, i	t the time, in my opini	date and on, death	clane, and occurred	d due to the d at the time, d	ate and place, ar	ner as a	stated: to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	2 /				License no				9d. Date signed			
)	lott		Mulyn	Vem	cuy 1	NW.)	D3!	5791		D	ecember	27,	2005	
(30. Name and address of paron who of Merlyn Vemury, M	i.D. 9801	. Georg	ia A	venue,	Sui	te 2:	27 , S	Silver	Spring,	MD	20902	
	Sta Registi		31. Date filed (Month, Day, Year) DEC 2 9 20	37 Registr	rar's Signature	do	ules								

DHMH 17 Rev 1/2001

		•	State Registrar			C	ertifica	te of	Death			Reg. No.		
	40		Decedent's Name (First, Midd								2. Date of D Month	eath Day	Year	3. Time of Death
	Physicia /Medic		DINAH	BLACKSTO	NE					1	DEC. 29			1:18 P M
	Examin		4a. Facility Name (If not institution SUBURBAN HOS		number)		,		SDA ,			4c. Count	y of Death	1
Ē	Funeral Director		5. Social Security Number 577–42–4034	6. Sex 1 ☐ M 2 🕱 F	1	(In yrs. last birtho	Months	Days	If Under Hours	24 Hrs. Min.	8. Date of 8 (Month, D JUNE	irth lay, Year) 28,1910	Cou	place (State or Foreign Intry) HINGTON, DC
		tor	Usual Residence of Decedent 10a. State 10b. Count MD MON	TGOMERY		10c. City, Town of BETHES								10d. Inside City Limits 1 ☐ Yes 2 X No
	with the	Director	10e. Street and Number	TANIE				ip Code 0817				10g. Citizen of	What Co	untry?
36	within 72 hours after death with the Maryland ane. than 'naturel', or items 23a or 28a-f show ta Medical Exe. interment be notified at	by Funeral	4925 BATTERY 11. Marital Status 1 Never Married 2 Ma 3 Widowed 47 Divorce	12. Was Do	Forces?	ver in U.S.	1	edent of H	lispanic Or an, Mexica Specify		ecify Yes or N Rican, etc.)		ack, White	ican Indian, , etc. HITE
Maryland 21215-0036	hin 72 hou s. n. "natura Medical E	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	nt's Education est grade complete	ed) e (1-4or 5+	(6	ecedent's Us Sive kind of w fe. DO NOT	ork done	dunna mos	st of work	ing	16b. Kind of		
d 21,	filed witl Hygiane other the	0	12 17. Father's Name (First, Middle	0			TYPIST		18. Moth	er's Name	e (First, Middi	US GOV e, Maiden Suma		ENT
ylan	Mental Mental arked c	ToB	MYER PERRY							BECCA			. 04-4- 7	- Code
Mar	nd 2 shoulth and 27 is m		19a. Informant's Name/Relation ROBERT M. BLA		- son	11					LLE, MD	ber, City or Town 20855	n, State, Z	ip Code)
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours aft Deperanent of Health and Mental Hygiane. International I		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other		om State	20b. Place of Cometery,	Crematory or EBANON	other pla	O	1/02		20c. Location	MD,	
Balti	permit. Depertmit imports any inju		21. Sign ture of Funeral Service	e Licensee	Jan							N FUNERA GTON, VA		
68760,	Certificate be executed indig physicien and indig physicien and indig physicien as the burial-transit	Ical Examiner	23a. Part 1. Enter the discorp. Shock, or heart failur. Li Immediate Cause (Final disease or condition resulting in death) Sequentially flet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. Due Si Due Mi c. Due	to (or as a EPSIS to (or as a ULTI to (or as a	the death. Do no electric consequence of AND SER a consequence of ORGAN SY a consequence of RENAL FA	OBE PROTIC SESTEM I	IEUMO IOCK	NIA	s cardiac (or respiratory	arrest.		Approximate Interval Between Onset and Death
P.O. Box 68		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12-gronths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Liv 4□Pri	e birth 2	of pregnancy 2 Fetal death time of death	3 ⊟Ectopic 5 □ Other (у				ate of deli	very Day Year
ds, P.	S C 0	þ	Part II. Other significant condi				he underlying	cause gr	ven in Part	1.				the cause of death?
Vital Records,	The law ete hes b pege 2 s	Completed									24a. We aut per 1 🗆 Yes	as an oppsy formed?	prior to death?	topsy findings available completion of cause of 2 No
/ita	Physicien: Th this cartificete ral director, peg	Be	25. Was case referred to medic examiner?	Unanimate	, HE	-		101	hac		th Check only			
5	Physic this cal dir	10	1 Yes 2 No	1.	Inpatier			DUA	4 🗆 N	lursing Ho		sidence 6 Co e how injury occ		cify)
Division of	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Certification:	3 Suicide 6 Coul	stigation	ate of Injur Month, Day	Year) Inj	M M		Yes 2]No				ıral Route Number,
<u>S</u>	oital or A urs after arsi Directilled in by	Certi	4 Homicide	ь	uilding, etc	. (Specify)				ad slass		own, State)	TARRAL 20	stated
	To the Hospital within 24 hours a To the Funeral completely filled	ledical	(Check only 2 Medic		e basis of nanner sta	examination and	or investigati	on, in my	opinion, de	ath occur	red at the tim	e, date and place	e, and due	to the cause(s)
)	V With	Σ	29b. Signature and title of certi		on	vaf		D0058	3965					TH 2005
	Ψ		30. Name and address of person DR. KHAWAJA,	SAIMA		11119	ROCKVI		PIKE,	STE 1	LOO,ROC	KVILLE,	MD 20	0852
102	St Regist	ate rar	31. Date filed (Month, Day, Yea JAN 0	3 2006	2. Negistra	ar's Signature	park	D						

DHMH 17 Rev 1/2001

Blackstone, Dinah 12/29/05

State of Maryland / Department of Health and Mental Hygiepe 05 Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year James Edgar Bacon 2005 29 955 Decamber /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HICOMICO Malon Comb SALWOUM PRINSULA 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | II Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) **Funeral** Min 1**X** M 2 □ F Davs Hours 87 219-07-7671 Director 5/10/1918 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ehow traumatic event, the Medical Examiner must be notified at Maryland Wicomico Salisbury 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1967 Pineway 21804 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 **X** Yes 2 □ No If Yes, Give Year or Dates:Army 1 Never Married 2 Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🛣 No Specify: δ 3 Widowed 4 □ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) 10 Maintenance Foreman E.I. Dupont Co. 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth eny ligury or other traumatic event 9058. 18. Mother's Name (First, Middle, Maiden Sumame) Lorenzo Dow Bacon Mary Ellen Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Ellen Archer/daughter 422 Worchester Dr., Dover, DE 19904 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Springhill Memory 4 □ Donation 5 □ Other (Specify) 1/3/06 Hebron, MD Gardens T. Signature of Funeral Service Licensee ²²Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 CFSP 9 Hompson 23a. Part1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physicien a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4☐Pregnant at time of death 5 Other (specify) ed by the a been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? cate hes t 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 20 No Be director, 25. Was case referred to medical 26. Place of Death Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3 DOA this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred 1 Matural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowled e death occurred at the limit date and flustration and countries as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kaw 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Din St. Set 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State JAN 03 2006 Registrar

The property of the property o				1 - For State Registrar	State of M	aryland		rtment of F tificate of			, ,	iene	5 1	3579
Examined Examin	3.	D)		1. Decedent's Name (First, Middle, Last,)								Voar	3. Time of Death
Security Fundamental Principle Callwert Memorical Responsibility of the Callwert Responsibility of the Callwert Memorical Responsibility of the Callwert Memorical Responsibility of the Callwert Responsib	ı			Gregory	Emmet	t	Cor	ndron]				5:50 p M
Second Second Processor Total Control To					street and number)	1		4b. City, Town, o	r Location	of Death		4c. County	of Death	<u> </u>
The part of the			À									Calv	ært	
Polystein Control of the Control	74			1/5			**				(Month, Day,		9. Birthpl Count	ace (State or Foreign try)
10.5 State 10.5 County 1		Director		214-84-4119	1.00	45	Yrs.				Jan 23	, 1960	Wash	1., D.C.
Section Sect		and				10c. City,	Town or Lo	cation					10	Od. Inside City Limits
Section Sect		daryl f sho	ō	MD Calvert				Chesans	ako	Read	h			1 XYes 2 No
Section Sect		the 28a-	rect							Douc		Da. Citizen of	What Coun	trv?
Section Sect		With 3a or		7005 Dational Dais					22					.,
Section Sect		ne 2;	era		12. Was Decedent		. 13. V			igin? (Spec	city Yes or No-			an Indian,
Section Sect	(C)	or Iter	Fur	1 X Never Married 2 ☐ Married	1 ☐ Yes 2 🔯						Rican, etc.)			etc.
Section Sect	ਲ ਲ	el', o		3 Widowed 4 Divorced	II Yes, Give		1	∐ Yes 2 <u>X</u> i No	Specify:	•		Specif	y: whi	te
Section Sect	2	72 hc	eted				16a. Deced	ent's Usual Occup	ation	at of workin	ia la	16b. Kind of B	usiness/Ind	ustry
Section Sect	2	ithin	du			5+)								_
Section Sect	2	ed w ygier ygier t, th	Cor				_ main	tenance						ol
Physician Middled Examiner Physician Middled Examiner Sequentially list conditions from the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the such arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arr	Ē	be fill										Maiden Suman	•	7 7 1
Physician Middled Examiner Physician Middled Examiner Sequentially list conditions from the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the such arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arr	<u>\</u>	Men Marke Marke	၉			on								
Physician Middled Examiner Physician Middled Examiner Sequentially list conditions from the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the such arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arr	a	2 sh and ris rr												Code)
Physician Middled Examiner Physician Middled Examiner Sequentially list conditions from the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the such arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arr	e)	1 and Healtl			con, rath				ourt,					un State
Physician Middled Examiner Physician Middled Examiner Sequentially list conditions from the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the such arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arr	0	iges if lite or of		1 🛱 Burial 2 ☐ Cremation 3 ☐ F		Cer	metery, crem	atory`or other plac	, i				•	
Physician Middled Examiner Physician Middled Examiner Sequentially list conditions from the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the such arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arr	₽	t. Pa rtmer rtant rjury				Ft.					l-06	Brenty	vood,	MD
Physician Middled Examiner Physician Middled Examiner Sequentially list conditions from the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, immediate Cause Final Sequence of the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the such arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arrest, and the mode of dyng, such as cardiac or respiratory arr	Bal	Depa mpo my Ir		1/1/0.	30							- 1		
Privisician (Medical Examiner Medical Examiner		and a distribution of the			·	d the death								A
Responded Cancer Due to (or as a consequence of): Due to (or as a consequence	H			shock, or heart failure. List only or	ne cause on each li	ine.	Do not ente	ar the mode or dyir	ig, such as	cardiac of	respiratory arre	est,		Interval Between
Sequentially list conditions cause. Einer Underlying Cause Disease or injury resulting in death Last Sequentially list conditions cause. Einer Underlying Cause (Disease or injury resulting in death Last Sequentially list conditions cause. Einer Underlying Cause (Disease or injury resulting in death Last Sequentially list conditions cause. Einer Underlying Cause (Disease or injury resulting in death Last Sequentially list conditions cause. Einer Underlying Cause (Disease or injury resulting in death Last Sequentially list conditions cause (Specify) Due to (or as a consequence of):				disease or condition	Esop	hagea	1 Cano	er						
Sequentially lat conditions a consequence of light properties of many resulting in death) Last Due to (or as a consequence of light properties of many resulting in death) Last Due to (or as a consequence of light properties of many resulting in death) Last Due to (or as a consequence of light properties of many resulting in death) Last Due to (or as a consequence of light properties of many resulting in death) Last Due to (or as a consequence of light properties of many resulting in death) Last Due to (or as a consequence of light properties of many resulting in death) Last Due to (or as a consequence of light properties of many resulting in death) Last Due to (or as a consequence of light properties of many resulting in death) Last Due to (or as a consequence of light properties of many resulting in death) Last Due to (or as a consequence of light properties of light properties of many resulting in death) Last Due to (or as a consequence of light properties of light pr				Tooding in doding	Due to (or as	a conseque	ence of):							
The state of the second property of the state of the second property	100		-	Sequentially list conditions,	Due to for as	3 00050 116	ance of							
Second S		ted	nlne	cause. Enter Underlying Cause (Disease or injury	Due to for as	a conseque	arice org							
Second S		xecurand al-trar	хап	that initiated events	Due to (or as	a conseque	ence of):							
FFEMALE: 23b. Was daceded pregnant in the past 12 months? 1 1 1 1 1 1 1 1 1	9	sician buria												
25. Was case referred to medical examiner? 1 Yes 2 Mo 27. Manner of Death 1 Mountail Moun	687	ficate phys	B		3.									
25. Was case referred to medical examiner? 1 Yes 2 Mo 27. Manner of Death 1 Mountail Moun	×	certi	/W		3c. If yes, outcome	of pregnan						23d Da	te of deliver	v
25. Was case referred to medical examiner? 1 Yes 2 Mo 27. Manner of Death 1 Mountail Moun	m	death a atter	ciai	in the past 12 months?					/			1		<u>'</u>
25. Was case referred to medical examiner? 1 Yes 2 Mo 27. Manner of Death 1 Mountail Moun	o	the c by the	hys		9□ Unknown									
25. Was case referred to medical examiner? 1 Yes 2 Mo 27. Manner of Death 1 Mountail Moun		s that ned b e deta	Y P	Part II. Other significent conditions con	ntributing to death b	out not result	ting in the un	derlying cause giv	en in Part I		23e. Did tob	acco use cont	ribute to the	a cause of death?
25. Was case referred to medical examiner? 1 Yes 2 Mo 27. Manner of Death 1 Mountail Moun	ğ	quire on sig uld b									1 ☐ Ye	s 2□No	3∰ Proba	abiy 4 ∐Unknown
25. Was case referred to medical examiner? 1 Yes 2 Mo 27. Manner of Death 1 Mountail Moun	00	s bee	Set								24a. Was ar		Were autop	sy findings available
25. Was case referred to medical examiner? 1 Yes 2 Mo 27. Manner of Death 1 Mountail Moun		The late has age 2	E								autops	ed?	death?	
Address of person who completed cause of death (Item 23a) (Type, Print) Address of person who completed cause of death (Item 23a) (Type, Print) Address of person who completed cause of death (Item 23a) (Type, Print) Address of person who completed cause of death (Item 23a) (Type, Print) Address of person who completed cause of death (Item 23a) (Type, Print) Address of person who completed cause of death (Item 23a) (Type, Print) Address of person who completed cause of death (Item 23a) (Type, Print) Address of person who completed cause of death (Item 23a) (Type, Print) Address of person who completed cause of death (Item 23a) (Type, Print) Address of person who completed cause of death (Item 23a) (Type, Print) Address of person who completed cause of death (Item 23a) (Type, Print) Address of person who completed cause of death (Item 23a) (Type, Print) Address of person who completed cause of death (Item 23a) (Type, Print) Address of person who completed cause of death (Item 23a) (Type, Print) Address of person who completed cause of death (Item 23a) (Type, Print) Address of person who completed cause of death (Item 23a) (Type, Print) Address of person who completed cause of death (Item 23a) (Type, Print) Address of person who completed cause of death (Item 23a) (Type, Print) Address of person who completed cause of death (Item 23a) (Type, Print) Address of person who completed cause of death (Item 23a) (Type, Print) Address of person who completed cause of death (Item 23a) (Type, Print) Address of person who completed cause of death (Item 23a) (Type, Print) Address of person who completed cause of death (Item 23a) (Type, Print) Address of person who completed cause of death (Item 23a) (Type, Print) Address of person who completed cause of death (Item 23a) (Type, Print) Address of person who completed cause of death (Item 23a) (Type, Print) Address of person who completed cause of death (Item 23a) (Type, Print) Address of person who completed cause of death	ta		a)						26 Place	of Death			Yes 2	2LI NO
1 Natural 1 Natural 2 Accident 3 Suicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 4 Homici		ysici is cer direc	0		lospital: 1X Inpatir	ent 2□E	R/Outpatient	3□ DOA Oth	or				et (Specify)
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and due to the cause (s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gwyneth Blattau, M.D. 110 Hospital Road, Ste. 310, Prince Frederick, MD 20678	0	g Ph er th			28a. Date of Inju	Jry 2	28b. Time of	28c. Injur	y at					
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and due to the cause (s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gwyneth Blattau, M.D. 110 Hospital Road, Ste. 310, Prince Frederick, MD 20678	ō	ath. rr: Alt	atlo		(Worth, Da	ly rear,	mjury			No				
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and due to the cause (s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gwyneth Blattau, M.D. 110 Hospital Road, Ste. 310, Prince Frederick, MD 20678	<u>N</u>	= 00 >	tiffe	datamined	28e. Place of Inj	jury - At hom	ne, farm, stre	et, factory, office		2	8f. Location (Str	eet and Numb	er or Rural	Route Number,
D 58572 January 1, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gwyneth Blattau, M.D. 110 Hospital Road, Ste. 310, Prince Frederick, MD 20678	ā	rs aft al Di ed in	Cer		Januariy, or						ony or roun.	, Glato)		
D 58572 January 1, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gwyneth Blattau, M.D. 110 Hospital Road, Ste. 310, Prince Frederick, MD 20678		tospi t hou uner	cal	(Check only 2 Medical Exami	sician: To the best	of my know	ledge, death	occurred at the tin	ne, date an	nd place, a	nd due to the ca	use(s) and ma	anner as sta	ited.
D 58572 January 1, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gwyneth Blattau, M.D. 110 Hospital Road, Ste. 310, Prince Frederick, MD 20678		the trin 24 the f	led	Une)	and manner st	ated.								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gwyneth Blattau, M.D. 110 Hospital Road, Ste. 310, Prince Frederick, MD 20678		To To	-	290. Signature and true of certifier	· Ma						29	u. Date signe	a (Month, D	pay, Year)
Gwyneth Blattau, M.D. 110 Hospital Road, Ste. 310, Prince Frederick, MD 20678)			Muntes	(1).D.				572			January	1, 2	006
21 Date filed (Marth Day Veer)		2												
Registrar JAN - 3 2006 Bayes & Spiller		Δ		21 Date filed (Month Day Year)	20 Deciete	- Cinnet				310,	Prince_	Freder:	ick, M	MD 20678
				JAN -	3 2006▶ ⊿	Bours	, K	book						

			1 - For State Registrar	State of M	Marylar		artment of rtificate o			lental Hy	giene	OOE	435	80
	81	à	Decedent's Name (First, Middle, La.	st)						2. Date of D Month			3. Time of D	Death
	Physici /Medic		CAROLYN LAL	RA CRO	PPEF	2						0, 2005	1945	\mathbf{P}^{M}
	Examin	er	4a. Facility Name (If not institution, giv		r)		4b. City, Town	n, or Location	n of Death			County of Death		
	Frankl		Atlantic General 5. Social Security Number 6. S	lospital 7./	Age (In yrs.	last birthday)	Berlin If Under 1 Ye		er 24 Hrs.	8. Date of B	irth W	orcester	place (State or	Foreign
	Funeral Birector			□M 2 X F	67	Yrs.	Months Da	ys Hours	Min.	8. Date of B	ay, Year)	38 Mary	ntry)	r or orgin
	D .		Usual Residence of Decedent 10a. State 10b. County			ty, Town or Lo	action	· · · · · · · · · · · · · · · · · · ·		Julie	43, 13		I0d. Inside City	. 1
	Aarylan I ehow	ō	Maryland Worceste	r			ocation						1 Tyes	,
1	the Maryla 28a-f ehor	Director	10e. Street and Number	21	Ber	III	10f. Zip Cod	le			10a. Citi	zen of What Cour		
15	h with	ai Di	10649 Racetrack	Pood			21811				U.S		,	
16	deatl	Funerai	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U	J.S. 13.	Was Decedent	of Hispanic C	Origin? (Sp	ecify Yes or N		14. Race - Americ Black, White,		
39.	or it	by Fu	1 Never Married 2 Married	1 □ Yes 2 X	₹No		1 ☐ Yes 2 🔯			1 110411, 010.)		Specify: Whi		
5-0036	within 72 hours after death with the Maryland ene. "Hen "hatural", or items 23e or 28e-f ehow na Medical Execution from the motified at		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates): 		dent's Usual Oc					nd of Business/In		
200	nin 72 n na Medik	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-40	r 5.4)	(Give	kind of work do DO NOT use re	ne durina m	ost of work	ing	100.11	na or basinosam	austry	
1 2 2	filed with Hygiene other the	Com	10		, 5+)	Home	maker				Fa	mily Car	е	
2 6 P	be filed within 7 ital Hygiene. Id other then "n	Be	17. Father's Name (First, Middle, Last,	1						e (First, Middle	e, Maiden	Surname)		
5-23 2-26 arvland	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the M	2	James "Shep" Tr			10h Maili	na Addrona /Ctr			Bradfo		r Town, State, Zip	Code	
0 C E			James T. Croppe	,, ,			9 Racet							
2 2 E	es 1 and of Health I item 27 r other tr		20a. Method of Disposition			Place of Dispo	osition (Name of matory or other	f		Berli Date		D 2181 cation - City or To		
000 000 altimor	Pege nent o nnt: if ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specil		8		lemorial		1/04	/06	Berl	in MD		
			21. Signature of Funera ervice Licer	1500			2. Name and Ad			108	Win	in, MD Nam Stre	eet	
<u> </u>	805 8 a		N. THE	2 untale		В	urbage	Funer	al Ho	me B	erlin	, MD 21		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each	ed the deal	/ /		, -		or respiratory	arrest,		Approximate Interval Betw Onset and De	een
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. INTEL	57,71	4//	4-9	diser	51				2 mer	-
	Examiner		- 1	Due to (or a	as a consec	quence of):	ť							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (cr a	sa di Cullatt	querice (ii).	4.1							-
	acuted nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
8760.	cate be executed by sician and the burial-transit		resulting in death) cast	Due to (or a	as a consec	quence of):								
87	physicate to the tree to the tree tree tree tree tree tree tree	dicai		_ d										
0 -X	eath certific attending p for use as 1	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom								23d. Date of delive	arv	
S OW	death e atte	Physician/Me	in the past 12 months?	1□Live birth 4□Pregnant	at time of c		∃Ectopic pregna ∃ Other (s <i>pecif</i> y					Month	-	ear
500	that the diad by the detached	hys	9 🗆 Unknown	9□ Unknown							-			
) 1 vi	s us es	þ	Part II. Other significant conditions	ontributing to death	but not res	sulting in the u	inderlying cause	given in Par	rt I.			ise contribute to the		
720	A requir	eted								-		☑Mo 3□Prot	oably 4 □Ur	iknown
₹.00 B	has by	Completed								24a. Wa auto	s an opsy formed?	24b. Were auto prior to co death?	psy findings at mpletion of car	vailable use of
542			25. Was case referred to medical	J		- 17. 70.	_	00.0		1 ☐ Yes	2 40		2 No	
22.5 52.5		To Be	examiner?	Hospital:	itient 2] ER/Outpatie	nt 3 DOA	Otto		h <i>(Check only</i> me 5□ Res		6 □Other (Specif	iv)	
してが			27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Ir (Month, L		28b. Time o		njury at Work?		28d. Describe			,,	
Ö	ttending death. stor: After the fune	catic	2 Accident investigation 3 Suicide 6 Could not be	n			М	1 🗆 Yes 2 l	□No					
Division	or A ifter Direction by	Certification:	4 Homicide determined	28e. Place of I	Injury - At h etc. (Speci	nome, farm, st fy)	reet, factory, offi	ice		28f. Location City or To	(Street an own, State	d Number or Rura)	al Route Numb	ΘΓ,
_	Hospital		29a. Certifier 1 Certifying PI	nysician: To the be	st of my kne	owledge, deat	h occurred at th	e time, date	and place.	and due to the	e cause(s)	and manner as s	tated	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Exal	miner: On the basis and manner	of examina	ation and/or in	ivestigation, in n	ny opinion, d	eath occur	red at the time	, date and	place, and due to	the cause(s)	
	To the To the complet	×	29b. Signature and title of certifier	11	-	1	29c. Lic	ense numbe				e signed (Month,	, ,	
			1 / 2		*	Sel.	H4	1428	3		12,	131/0	5	
25	1 10		30. Name and address of person who Robert Dur	completed cause of	P33	m 23a) (Type, Hezi	Print) Thu24	Drie	4	Be	lis	/31/0. , mi)		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JAN 0 3	2006 32. Pagis	strar's Sign	ature	Print) The way						·	

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. U 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) December 27,2005 11:40AM M **Physician** Gertrude Coombs S. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Takoma Park Washington Adventist Hospital Montgomery County 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. | Mayont 1924 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 577-34-5569 1□ M 🏠 F Kershaw, SC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Itema 23a or 28a-f show The Medical Exactiner must be notified at 1X Yes 2 □ No MD Prince Georges Directo Cheverly 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20785 2540 Wayne Place United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or item any injury propher traumation. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Black Baltimore, Maryland 21215-0036 Specify: 3 \ Widowed 4 □ Divorced 2 Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Rockland State College (1-4or 5+) Elementary/Secondary (0-12) Nurse Mental Hospital 2 years injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Cornelious Segears Sylvia McAskill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3322 14th St. NW #405 Washington, DC 20010 Vearlie Mae Segears/ Sister 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Maryland National Cem. 1√ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/4/06 Laurel, MD 21. Signature of Funeral Service L 22. Name and Address of Facility Austin Royster Funeral Home 3821 14th St. NW Washington,DC 20011 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one sause on each line Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examine ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒No 24a. Was an After this certificate has perform 1 🗌 Yes 2 No To the Hospital or Attending Physician: Within 24 hours after death.
To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 Sepatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident the 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the 29b. Signature and title of certifier 29c. License number 7600 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Merenn MX 31. Date filed (Month, Day, Year) 32 Registrar's Signature State DEC **3 0** 2005 Registrar

		•	For State Registrar	State of I	Marylan	d / Depa <i>Ce</i>	artmer <i>rtifica</i> i	nt of H te of L	ealth ar Death	nd Me		iene g. No.	05	358	32
36	Dhusisi		1. Decedent's Name (First, Middle, L	ast)							Date of Deat Month		Year	3. Time of	
	Physici /Medic		DAVID CHU	CHEN]	Month DECEMBER			11:27	7 AM
	Examin	er	4a. Facility Name (If not institution, g.						Location of	Death			ounty of Death		
	27		SHADY GROVE ADVENTS 5. Social Security Number 6.		Age (In yrs.	last hirthday)		CKVILI r 1 Year	LE If Under 24	4 Hrs.	3. Date of Birth		NTGOMERY	place (State o	or Foreign
1. 。添	Funeral Director		321-68-3002	1⊠M 2□F	50	Yrs.		Days	Hours	Min.	(Month, Day, 10/27/19	Year)	TAIW	ntry)	n i diaign
1000	D		Usual Residence of Decedent												
	nylan show	_	10a. State 10b. County	117		y, Town or Lo	ocation							10d. Inside Ci	ity Limits 2X No
	Ba-f e	Director	MARYLAND MONTGOMER	ΚΥ	RO	CKVILLE									2.01140
	with the		10e. Street and Number 2211 NEWTON DRIVE					0850			1	-	on of What Cou JSA	ntry'?	
	na 23,	erai	11. Marital Status	12. Was Decede	ant Ever in U	S. 13			spanic Origi	in? (Spec	rfy Yes or No-		. Race - Ameri	can Indian.	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itema 23a or 28a-f ehow important: if Item 27 is marked other than "natural", or Itema 23a or 28a-f ehow in your opposite traumatic event, Ira Madical Examinal must be notified at once.	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force	es? [∑] No		lf Yes, spe	city Cuba	Specity:	Puerto R	ican, etc.)		Black, White,	etc.	
Q Q	72 ho	ted	15. Decedent's (Specify only highest g			16a. Dece	dent's Usu	al Occupa	ation luring most of	of workin	7	16b. Kind	d of Business/Ir	ndustry	
2	ithin	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT I	ise retired)		,	CELE	EMDLOVE	D.	
2	led w tygier her th		17. Father's Name (First, Middle, Las	5+			ARTIS	1	18 Mother	's Name	First, Middle, I		-EMPLOYE	D	
auc	od of	Be	FU-CHI CHEN	»(<i>)</i>					SHI	CHU			umamo)		
<u> </u>	Should Dd Me mark matk	은	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Addres	s (Street a			Route Number		Town, State, Zij	p Code)	
<u>₹</u>	alth ar 27 ls		JOANNE CHIUNG-CHIUNG	G CHANG/WIFE		2211	NEWTON	DRIV	E; ROCK	VILLE	MD 20850)			
Baltimore,	Pages 1 a		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		ate FOR	Place of Disponenter, creater,	osition (Na matory or LN CRI	me of other plac EMATOR	g) Y 1	Da /3/20			ation - City or T WOOD, MD		
Balti	permit. Departm Imports eny inju		21. Signature of Funeral Service Lic	oler t							S-RINALDI ; SILVER				
10 cm	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on eac	th line.	n can	t-a			ardiac or	respiratory arm	est,		Approximat Interval Bet Onset and	tween Death
	/Medical Examiner			40	as a conseq									hour	
		e	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying	D	as a sunseq									7,00	
	cate be executed physicien and the burial-transit	Examiner	that initiated events	C.											
8760,	cate be executed physicien and the burial-transit	ai Ex	resulting in death) Last	Due to (or	as a conseq	uence of):									
687	physicate physicate	edicai		d.	_										
.O. Box (ie death certific the attending p hed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		h 2∏Feta ntattime of d	Ideath 3	⊒Ectopic p ⊒ Other (s					23	d. Date of deliv Month	-	Year
Д.	The law requires that the de ate hes been signed by the a page 2 should be detached t	/ Ph	Part II. Other significant conditions	contributing to dea	th but not res	ulting in the u	Inderlying	cause give	en in Part I.		23e. Did tol	bacco use	e contribute to	the cause of o	death?
rds	w requires tha been signed I should be det	ed by	Brain TUN	ان ر							1 🗆 Ye	es 2 🗆	No 3 ☐ Pro	bably 4	Unknown
of Vital Records,	law re es bee 2 sho	Completed									24a. Was a		24b. Were aut	opsy findings	available
Œ	The ate h	Com									perform		death? 1 ☐ Yes	252 No	
/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Hannitali				0"		of Death	(Check only on	18)			
on of	ding Physicien: h. After this certifics funeral director, p	tion: To	1 Yes 2 No 27 Manner of eath 1 Natural 5 Pending 2 Accident investigat		-	ER/Outpatie 28b. Time of Injury		28c. Injun Worl	at at	2	e 5 🗌 Reside 3d. Describe ho			ify)	
Division	il or Attending after death. I Director: After d in by the fune	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of	f Injury - At h	ome, farm, st					Bf. Location (St City or Town	reet and n, State)	Number or Rur	al Route Nurr	nber,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier 12 Certifying (Check only one)	Physician: To the b aminer: On the bas and manne	is of examina	owledge, deat ation and/or in	h occurred	d at the tin	ne, date and pinion, death	place, ai	nd due to the ca	ause(s) a ate and p	nd manner as solace, and due to	stated. to the cause(s	s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	0			29	c. License		_ ^	2		signed (Month,		
)	(D		I liam 5 m	72	M.0			0	599	27		iz.	-25-0)	
l			30. Name and address of person wh	o completed cause	of death (Iter	п 23а) (Туре	Print)								
100			AARON SNYDER M.D. 9 31. Date filed (Month, Day, Year)	901 MEDICAL	CENTER gistrar's Signa				D 20850)					
27	Sta Regist	ate rar	DEC 30	2005	Mars 1	& A	ack	P							

State of Maryland / Department of Health and Mental Hygiene

63583 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** 31, DECEMBER ANNIE RUTH LANCASTER CHESLEY 2005 1:57 PM /Medical 4b. City, Town, or Location of Death 4a Fecility Nama (If not institution, giva street and number) 4c. County of Death Examine LAYHILL CENTER, GENESIS HEALTHCARE SILVER SPRING MONTGOMERY 8. Data of Birth (Month, Day, Yaar) MARCH 7, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Aga (In yrs. lest birthday) 9. Birthplaca (Stete or Foreign **Funeral** Months Days Hours 1□M 2□F Yrs 1917 220-16-5237 88 MARYLAND Director Usuel Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Meryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23s or 28e-f show ary or other treumstic event, the Medical Examinal must be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo MARYLAND CHARLES LA PLATA 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7760 BUMPY OAK ROAD 20646 UNITED STATES Funeral 14. Race - American Indian, Black, White, atc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Merried 2 Merried Maryland 21215-0036 1 ☐ Yas XXNo Specify: Specify: BLACK 2 If Yes, Give 3 ☐ Widowed 4 Divorced Yeer or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grede completed) 16b. Kind of Businass/Industry College (1-4or 5+) Elemantery/Secondery (0-12) 12TH GRADE TEACHERS AIDE **EDUCATION** 17. Father's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumama) Be JAMES WILLIAM LANCASTER ROSE ELLA HAWKINS LANCASTER 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rurel Route Number, City or Town, Stata, Zip Code) A. YVONNE CAMPBELL / DAUGHTER 9508 TELLICO PLACE, CLINTON, MARYLAND 20735 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State JOSEPH'S CHURCH CEM. 1/6/2006 POMFRET. MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) And Service Librage THORNION FUNERAL HOME, P.A. LYDIA C. THORNTON JOHNSON MO0583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 23a. Pert1. Enter the disease, or complications that caused tha death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina. Approximata Interval Batween Onset and Daath Physician /Medical Immediate Causa (Final diseasa or condition rasulting in daath) **ENCEPHALOPATHY** Examiner Due to (or es a consaquence of): Examiner SEIZURE DISORDER physicien end s the buriel-trensit Attending Physician: The law requires that tha daath certificate be executed Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disaasa or injury that initiated events Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequanca of) resulting in death) Last use es attanding of for use es signed by the a Id be datached f Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTENTION 2 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy CORONARY ARTERY DISEASE parformad? has pege 2 1L Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Othar (Specify) P 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this : After thi 27. Menner of Deeth 28c. Injury at Work? 28b. Time of 28d. Dascribe how injury occurred Certification: Injury 5 Panding death. 1 Yes 2 No investigation i Director: A 2 ☐ Accident 6 Could not be datermined 3 Suicide 28a. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida hours after ö To the Hospital within 24 hours To the Funeral Completely filled Hospital filled 1 Certifying Physician: To tha best of my knowladga, daath occurrad at tha tima, data and plece, and dua to tha causa(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination end/or invastigation, in my opinion, daath occurrad at the tima, data and place, and dua to the causa(s) and manner stated. 29a. Certifia: edical (Check only one) 29c. License number 29b. Signature and fittle of certifier 29d. Date signed (Month, Day, Year) tino D56691 **DECEMBER 31, 2005** 30. Name end edd s of person who complated causa of daeth (Item 23a) (Type, Print) MP GHOUSIA SULTANA, M.D. - 12107 HERITAGE PARK CIRCLE, SILVER SPRING, MD 20606 P.A. 32. Registrer's Signature 31. Dete filed (Month. State 3 2006 asur

DHMH 16 Rev 6/95

Registrar

ORIGINAL

		_1	For State Registrar		State of Ma	aryland / Dep Ce	ertificate of		Re	g. No.	5	43584
	sicia: edica	1	James	e (First, Middle, Li A	Cooper				2. Date of Deat Month Decemb		ŏ5	3. Time of Death 10:55 AM
	mine	r 4	ta. Facility Name (/ Casey Ho	_	ve street and number)		4b. City, Town, o	r Location of Death $1 ext{e}$		4c. County Montg		ry
Fune			5. Social Security N	umber 6.	Sex 7. Ag 1X1XM 2□ F 5.4	e (In yrs. last birthda) Yrs.	// If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth June 5	, °°°° 951	9. Birthp Wasi	place (State or Foreign
yland	ı		Usual Residence of 10a. State	Decedent 10b. County		10c. City, Town or					1	I0d. Inside City Limits
death with the Maryland ims 23a or 28s-f ehow		5	D.C.			Washingt		•				¶∑Yes 2 No
with th	i		10e. Street and Nur				10f. Zip Code			Og. Citizen of W		
IDICS, INSTITUTED A 12 10-0000 ges 1 and 2 should be filed within 72 hours after death with the Marylan tt of Health and Mental Hygiene. If filem 27 is marked other then "natural", or itema 23a or 28a-1 ehow or of his treumatic event. The Medical Examiner rust be notified at		by rune	11. Marital Status	ayes St ied 2⊡ Married 4 ⊠Divorced	12. Was Decedent Armed Forces? 1 Yes 2 Y	Ever in U.S. 13	20017 . Was Decedent of Hif Yes, specify Cuba	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - Americ k, White,	can Indian,
72 ho		ered	(Spec	15. Decedent's E cify only highest g	Education rade completed)	16a. Dec	edent's Usual Occup e kind of work done DO NOT use retired	pation during most of work	ing	16b. Kind of Bu	siness/Inc	dustry
within iene.		Completed	Elementary/Seco	ndary (0-12)	College (1-4or 5		ontracto			Self e	mplo	oyed
De fifed tal Hyg		0 0	17. Father's Name					18. Mother's Nam		faiden Sumam	e)	
hould to Meni	ı	2	Samue I 19a. Informant's Na	L. COO		19h Mai	ling Address (Street		E. Pope	City or Town	State 7in	Code
nd2s and2s althan 27 ion					per (daug							lboro Md.
permit. Pages 1 and Dependent of Heall Important: If Item 2 and Indiany or other 2		1	20a. Method of Disp 1X Burial 2 4 □Donation		□Removal from State		position (Name of ematory or other place ncoln	ce)	13/06 I	oc. Location - Brentw		own, State
Dependit. Dependit	once.		21. Signature of Fu	neral Service Lice	nsee		22. Name and Addre	Cec	lar Hil			Home Md.20746
			23a. Part . Enter the shock, or hea	he disease, or cor rt failure. List on	nplications that caused y one cause on each lin	10.	nter the mode of dyir	ng, such as cardiac	or respiratory arre	est,	and	Approximate Interval Between Onset and Death
Physicia /Medic			Immediate Cause disease or condition resulting in death)	(Final on	Pneum							Onset and Death
Examin			Constitution of the state of th		HIV/A	a consequence of):						
ed sit			Sequentially list co if any, loading to in cause. Enter Unde Cause (Disease or	inditions, imadiata orlying	Due to (or as	a consequence of)						
icate be executed physicien and si the burial-transit		LXar	that initiated events resulting in death) I	· · · · · · · · · · · · · · · · · · ·	c. Due to (or as	a consequence of):						
		acical			d	-						
The Cords, P.C. BOX of The law requires that the death certificate has been signed by the attending page 2 should be detached for use a		ĚΙ	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant at 9☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	<i>'</i>		23d. Date Mor	e of delive nth	ery Day Year
w requires that the second by should be detailed.	1	ן בּ	Part II. Other signif	ficant conditions	contributing to death b	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did tob			ne cause of death?
The law reate has bee		Completed							24a. Was ar autopsy perform 1 Yes 2	pled? d	Vere autoporior to con leath?	psy findings available mpletion of cause of 2 No
VICAL IICIAN: T Certificat Fector, pa	0	0	25. Was case refer examiner?		Hospital:		ont 3 DOA Oth	Of:	h (Check only one	-		
LIVISION ON VICEI THE TO THE HOSPITED TO THE HAND WITHIN 24 hours elter death. To the Funeral Director: After this certificate has completely filled in by the funeral director; Agent to settificate has		5	1 ☐ Yes 2X 27. Manner of Deat 1 ☒ Natural		28a. Date of Inju (Month, Da	nt 2 ER/Outpati ry 28b. Time y Year) Injury	of 28c. Injur Wor	Thursing Ho	me 5 Resider 28d. Describe ho			1)
DIVISION ATTOMISM SINGLE AND ATTOMISM SINGLE A		Cermican	2 Accident 3 Suicide 4 Homicide	6 Could not determine	be on Diese of Init	ury - At home, farm, s c. (Specify)			28f. Location (Str City or Town	eet and Numbe , State)	er or Rura.	l Route Number,
ne Hospitu 24 hours ne Funera detely fille			29a. Certifier (Check only one)	1 ★ Certifying P 2 Medical Exa	hysician: To the best miner: On the basis of and manner sta	examination and/or	ath occurred at the tir nvestigation, in my o	me, date and place, pinion, death occurr	and due to the ca red at the time, da	use(s) and mar ite and place, a	nner as st	ated. the cause(s)
To th withir To th			29b. Signature and	title of certifier	MO		29c. Licens	e number		d. Date signed		
1		-		TOUS)	W.		1 64	11218		ec. 24	± 20	05
R				ess of person who	completed cause of d	eath (Item 23a) (Type 1 Munca:	•	-ת גם ו	\ale	- 343		
	State		31. Date filed (Mon		32. Registra	ar's Signature	6	+ NU. K	PURVIII (e, Ma.	208	155

DHMH 17 Rev 1/2001

Ogôss				ype or Prin								_		pur 186
		-	FOR	State of Ma							Com		358	35
			- State Registrar AMEND#4a, perME 1. Decedent's Name (First, Middle, Last)	12/29/05 DE	5,1400	o Cer	lilica	e or L	Death	2. Date of Dea	Reg. No).	3. Time o	f Dooth
Phys	icia	n		Cameron						Month	Da			
/Me	dica		4a. Fecility Name (If not institution, give si				4b Cib	Town	Location of Death	Decembe		22, 2005 County of Death) A ^M
Exan	nine	r	400 E Schuyler Str	D 7					Spring			lontgomer		
Funer			5. Social Security Number 6. Sex		e (In yrs. I	ast birthday)	If Unde	r 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9 Birth	place (State	or Foreign
Funer Directo			213-56-6566 ^{1□}	M 2∏ F	57	7 Yrs.	Months	Days	Hours Min.	Nov. 5,	y, Year	48 Wash	ntry) ington	, DC
D.		ļ	Usual Residence of Decedent											
arylar show		١,	10a. State 10b. County	2017		, Town or Lo zer Spi							10d. Inside C	2X No
Ba-f	.	Director	Maryland Montgome	ГУ	DIIV	er pbi		0.4-			10- 0	Al		
with th	i	5	10e. Street and Number 400 East Schuyler	Road				p Code 0901			10g. Ci	tizen of What Cou USA	intry?	
death with the Maryland me 23s or 28s-f show rmust be notified at		Funeral		2. Was Decedent I	Ever in U	S 13 1	Was Dec	edent of Hi	ispanic Origin? (Sp	acify Yes or No-		14. Race - Amer	can Indian	
ter d		5	1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 ☐ N		1	If Yes, sp	cify Cuba	n, Mexican, Puerto	Rican, etc.)	Ē	Black White	etc	
hours af		2	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 🗆 Yes	2☐No	Specify:			Specify: Whit	е	
2 ho		led ed	15. Decedent's Educ (Specify only highest grade	ation		16a. Deced	dent's Usi	ual Occupa	ation	king	16b. H	(ind of Business/li	ndustry	
thin 7	3	<u>a</u>	Elementary/Secondary (0-12)	College (1-4or 5	i+)				during most of work	(III)		T		
ed wi	8	Completed				ге	gaı :	Secre				Law		
d I C I C I D-UUSO d be filed within 72 hours after antal Hygiene. ced other then "natural", or its		Re	17. Father's Name (First, Middle, Last) Robert Jackson Ha	11					18. Mother's Nam	ne <i>(First, Middl</i> e, uth Skoc		n Sumame)		
Daltimore, Maryiann ZIZIS-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Itame 23a or 28a-1 show any Injury or other traumatic event, the Medical Example or mailed at any Injury or other traumatic event, the Medical Example or must be publicated.	1	0				101 11 11		(0)				T 0	2.11	
Vial 12 sh h and 7 is n traun			19a. Informant's Name/Relationship (Type Eileen R. Marcoe/						and Number or Ru. pel Road					
C, E 1 and Health em 27 ther tr		÷	20a. Method of Disposition		20b. P	lace of Dispo	sition (Na	me of	1_	Date	20c. L	ocation - City or T	own, State	
Pages nent of nrt: if it	i	i	1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	C	emetery, crer ropolit	natory or	other plac		mber 27 005		andria,		nia
Dallimo	9	+	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of/Funeral Service Listense	e 1										
Dall permit. Departm Importa	ouce	4	Yra V	Souls		5	ranc: 00 Ui	niver	ss ctorlyins sity Blv	d, W, Si	ilve	er Spring	, MD 2	20901
		1	23a. Part Y. Enter the disease, or complic shock, or heart failure. List only on	cations that caused	the death	n. Do not ent	er the mo	de of dyin	g, such as cardiac	or respiratory ar	rest,		Approxima Interval Be	te
Physicia	an		Immediate Cause (Final										Onset and	Death
/Medic			disease or condition resulting in death)	Due to (or as			(KUI	ivascum	NC DISTO	MS K			
Examin	er		Conventially list conditions											
D ==	-	Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	Due to (or as	a consequ	uence of):								
executed executed an and rial-transif		Examiner	Cause (Diseese or injury that initiated events c. resulting in death) Last											
be exe		ᇤ	resulting in death) cast	Due to (or as	a consequ	uence or):								
	:	a ca	Q d											
death certificate ettending phys		Physician/Medic	IF FEMALE: 23	3c. If yes, outcome	of pregna	incv						23d. Date of deliv		
BOX eath cer ettendir for use		lan	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Feta	I death 3	Ectopic Other (s	oregnancy				Month		Year
the d		Š	1 ☐ Yes 2 ☐ No 9 🖭 Unknown	9□ Unknown				,,						
ords, F.C. I requires that the delen signed by the e	1	oy F	Part II. Other significant conditions con	tributing to death b	ut not res	ulting in the u	nderlying	cause give	en in Part I.	23e. Did to	obacco	use contribute to	the cause of	death?
ras quires in sign		<u>α</u>	CHRUNIC ALCOHU	usm						101	res 2	900 3 □ Pro	bably 4 🗆	Unknown
- D 70		Set	CIRRMOSIS							24a. Was		24b. Were aut	opsy findings	available
P 0 F 9		Completed	ASLITES								rmed? 2 □ No	24b. Were aut prior to co de th?	2 □ No	cause or
VITAL P ician: Th certificete rector, pag		e l	25. Was case referred to medical						26. Place of Dea					
TV nysic nysic nysic l direc		0	examiner? 1 Yes 2 No	ospital: 1 Inpatie	ent 2	ER/Outpatier	nt 3 🗆 🗆	OA Oth	er: 4 Nursing H	ome 5□ Resid	dence	6 Other (Spec	MISCLI	10
VISION OT VITA Attending Physician: or death. ector: After this certific by the funeral director,			27. Manner of Death 1. Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury		28c. Injun World		28d. Describe	now inju	iry occurred		
SIO eath. or: A		cati	2 Accident investigation 3 Suicide 6 Could not be				M		Yes 2 □No					
		Certification:	4 Homicide determined	28e. Place of Inj building, et	ury - At ho c. <i>(Specif</i>)	ome, farm, str y)	reet, facto	ry, office		28f. Location (S City or Tox		nd Number or Rui 'e)	a <i>l Route Nun</i>	nber,
DIVISION OT VITA spital or Attending Physician: ours effer death. nerel Director: After this certific filled in by the funeral director,			29a. Certifier 1 Certifying Phys	inione To the best		uuladaa daati								
Hos 24 ho Fun		Medicai	29a. Certifier 1 Certifying Phys (Check only one)		f examina									s)
To the Hospital o within 24 hours eff To the Funerel D completely filled in		ē Z	29b. Signature and title of certifier	J			2	9c. Licens	e number		29d. Da	ate signed (Month	Day, Year)	
⊢ s ⊢ ō			\rightarrow \times \wedge	1-				OCME			Dec	ember 23	2.005	;
			30. Name and address of person who co		leath (Iten	n 23a) (Type,							, =====	_
5			Mary of R	188 Lin	2		11	1 Per	n Street	Baltimo	ore.	Marylar	d 2120	1
	Stat		31. Date filed (Month, Day, Year)	32. Progistr	ar's Signa	ture	baste	,						
Reg	istra	r	DEC 292	CUU	w.	N M	Kara - Co							

			for State Registrar	State of Maryl		artment of F		nd Mental	Hygiene Reg. No	UUJ	43586
*	Physici /Medic		1. Decedent's Name (First, Middle, La GLORIA ANN	CROWI	И			2. Date of Month	IBOR 3), ZVÖ	3. Time of Death
	Examin	er		NTIST HOSPITA		4b. City, Town, o	LE		٨	County of Dea	MERRY
	Funeral Director		210-34-3324	~ · · · · · · · ·	rs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Monti	of Birth n, Day, Year) 14 19		thplace (State or Foreign ountry) Maryland
	show	٥٢	Usual Residence of Decedent 10a. State 10b. County Md. Monto	omery 10c.	City, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 No
	or 28a-f	Directo	10e. Street and Number 14148 Travilah B	-	1.00,114	10f. Zip Code	2085	50		tizen of What C	ountry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilt and Mental Hygiene. Integrate: It tiems 23 a or 28s-f show important: If tiem 27 is answerled other than "natural; or items 23a or 28s-f show any nijdry or other traumatic event, the Modical Exeminar must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Vidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 🕱 No If Yes, Give		Was Decedent of Hif Yes, specify Cub.				14. Race - Am Black, Whi	erican Indian,
2-00	72 hour	eted b	15. Decedent's E (Specify only highest gra		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	ation during most	of working	16b. K	ind of Business	/Industry
Maryland 21215-0036	led withir lygiene. her than	Completed	Elementary/Secondary (0-12) 10	College (1-4or 5+)		ssembler				Electro	nics
yland	buld be fil Mental H arked ott atic even	To Be	17. Father's Name (First, Middle, Last Lucian Brighan				Mar Mar	's Name (First, Mi	odie, Maider wartzł	_	
Mar.	and 2 sho laith and 27 is m er traume		19a. Informant's Name/Relationship (Donna J. Roberts			ng Address (Street) Ancient					
Baltimore,	Pages 1 a		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specia	Removal from State	-	osition (Name of matory or other plan ille Ceme		Date 1/4/06		ocation - City of aytonsv	Town, State
Balti	pemit. Dep. rtm Importa any nju		21. Signature of Funeral Service Lice	N Bar	Lev 2	Name and Addre		oer Funer 38, Layto			20882
	Physician		23a. Part 1. Enter the disease, or bom shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the done cause on each line.	0 1 0 A 1					re, mu.	Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as a con		OLMS DI	BUTTER	HNS			to wks
.00	cate be executed hysician and the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a con	SPLANT	REJECTIC	N				6 WKS
(68760	artificate ting physic	Medical	IF FEMALE:	d							
P.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)	у			23d. Date of de Month	livery Day Year
rds, P	quires that the de n signed by the a uld be detached f	þ	Part II. Other significant conditions of	contributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.			_	o the cause of death?
		Completed							Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
Ž	Physiciar this certif al directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 🗆 ER/Outpatie	nt 3 DOA Oth	000	of Death (Check of sing Home 5 🗆		6 □Other (Spe	əcify)
sion o	ding Ph L After th funeral	Certification: 7	27. Manner of Death 1. Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be			M 1		28d. Desc	ribe how inju	ry occurred	
N N	in Diffe		4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, st ecify)	reet, factory, office			on (Street ar r Town, State		ural Route Number,
	To the Hospital within 24 hours and to the Funeral Completely filled	edicai	(Check only 2 Madical Examone)	nysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	vestigation, in my d	pinion, death	I place, and due to h occurred at the t	the cause(s ime, date and) and manner a d place, and du	s stated. e to the cause(s)
	15	Σ	29b. Signature and title of certifier	I-MD		29c. Licens 036	se number			te signed (Mon ARY 01,	•
	13		30. Name and address of person who	dompleted cause of death (Item 23a) (Type,) RG1A-H	Print) (E#SN)	WHEAT	TON MD	20902)	
* * * * * * * * * * * * * * * * * * *	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 3 2	32 Registrar's Si	gnature	sult.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 5 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 05/UM December Z4 2005 Inwood /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SALISBUR 2065136 TNOURAGE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 1/1/1938 Birthplace (State or Foreign Country)
 Virginia 6 Sax 7. Age (In vrs. last birthday) **Funeral** Days 1**X** M 2 □ F 229-46-0120 Yrs. 67 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Virginia Fauquier Catlett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Iteme 23a 11039 Brent Town Rd 20119 Completed by Funeral USA 12. Was Decedent Ever in U.S.
Armed Forces?

1 ▼Yes 2 □ No
If Yes, Give Coast Guard 1 □ Yes 2 ▼No
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Specify: white 3 Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) f Health and Mental Hygiene. Item 27 is marked other then College (1-4or 5+) 12 Career military U.S. Coast Guard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stansbury Charnock Sr. Lillie Bell Richardson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard D. Charnock/son 33902 Susan Beach Rd., Laurel, DE 19956 20b. Place of Disposition (Name of cometery, crematory or other place)
Quantico National 20a. Method of Disposition Date 20c. Location - City or Town, State ō = ō 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or Triangle, VA 4 ☐ Donation 5 ☐ Other (Specify) 1/3/06 21- Figurature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Fario 24 Hompson CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatie Melanoma 2 years resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated autonations) Examiner Que to for as a consequence off The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physicien Completed by Physician/Medical as the IF FEMALE nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ò in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No should be detached the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ⊡ No 1 Tyes 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed2 certificate 2 No or Attending Physician: completely filled in by the funeral director, Be 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No s after death 2 Accident 6 Could not be 3 T Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

£"

7

Registrar

State

zul ni

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 03 2006

DIVISION

32. Registrar's Signature

ALISB R

D057359

Usha Natesan

29 15 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 1 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day CHARLES RAYMOND CASPER DEC 29 2005 11:49A 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death WASHINGTON ADVENTIST TAKOMA PARK MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**X**M 2□ F Yrs. 375-07-1929 89 NOV MI Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No MD MONTGOMERY SILVER SPRING 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 13817 VINTAGE LANE 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No 1938— If Ves, Give Year or Dates: 1960 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done du life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) 4 PROCUREMENT OFFICER CIVIL SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) BERNARD CASPER ANNA ULENBERG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20879 19a. Informant's Name/Relationship (Type, Print) KEITH CASPER / SON 20701 BELL BLUFF RD., GAITHERSBURG, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State * 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON CEMETERY 2/3/06 ARLINGTON, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, MD 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or ue confer uence of): Sequentially list conditions, it cary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of); resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. D te of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 1 Natural 2 Accident 5 Pending investigation

Physician /Medical Examiner The law requires that the death certificate be executed attending physiclan for use as the buria Division of Vital Records, P.O. Box 68760,

funeral the Examiner

cal

by Physician/Medi

Completed

Be

P

Certification:

Medical

State

Registrar

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

in then "naturel", or Items 23a or 28e-f ehow the Medical Examiner must be notified at

e filed within 72 hours after deeth at Hygiene. other then "naturel", or Items 23

Pages 1 and 2 should be nent of Health and Mental ant: If Item 27 is marked o

permit. Page Department of Importent: If any injury or once.

Baltimore, Maryland 21215-0036

with the Maryland

or Attending Physician: efter death Director: within 24 hours e To the Funere! [

After

OTIVA

ANJUM 31. Date filed (Month, Day, Year)

JAN 0 3

3 🗌 Suicide

29a. Certifier

4 Homicide

6 Could not be determined

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

DECEMBER 29 2005

pleted cause of death (Item 23a) (Type, Print) CARROLL AVE. TAKOMA PARK Md. 20912 7610

32. Regist 2006

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Catherine Genevieve Carter December 27, 2005 10:25 P ^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 23, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign
Country) Months Days Hours Min. 1 □ M 2 🖾 F 82 1923 Maryland Director 218-24-2854 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Itam 27 is marked other than "natural", or Itams 23e or 28e-f shov other traumatic event, I've Medical Exter it at must be notified at 1 ☐ Yes 2 ☐ No Directo Montgomery Maryland Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 25723 Woodfield Road 20872 death U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black à 3 ☑ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 and Mental Hygiene, 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Fleming Eva S. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) iges 1 and 2 s it of Health an 8209 Warfield Road, G Lauretta B. Miles - Daughter Gaithersburg, Maryland 20882 ate 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Dapartment of Important: If any Injury or once. * 4 □ Denation 5 □ Other (Specify) Friendship Methodist Cemetery 1/2/06 Damascus, Maryland 21. Signal are of Funeral Service Licensee 22 Name and Address of Facility Molesworth—Williams P.A., Funeral Home Kovert & 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of): Examiner ba 50 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to or as a consequence of Examine certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physicien Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown by, been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has rmed? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes : After this certification of the formula director, I To the Hospitel or Attanding Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other $_{4\,\square\,\text{Nursing Home}}$ 5 \square Residence 6 \square Other (Specify) \square Hospice Hospital: 0 1 ☐ Yes 2 🙀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending hours after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide in by 1 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Danne D0034682 December 29, 2005 2 and address of person who completed cause of death (Item 23a) (Type, Print) Joanne L. 9701 New Church Street, Damascus, Maryland Kinney, M.D. 31. Date filed (Month, Day, Year) 0 3 20062. Registar's Signature State Registrar

RJ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of	Marylar		artment o			lental Hy	giene Reg. No		43590
	Physici	an	Decedent's Name (First, Middle	Last)						2. Date of Do Month	eath Da	y Year	3. Time of Death
	/Medi	cal	Lauren Elizabet							Decemb	er 3	0, 2005	
1	Examir	er	4a. Facility Name (If not institution,		ber)			m, or Location				. County of Dea	
	- Francis		11303 Green Val		Age (In vrs.	last birthday)	Union If Under 1 Y		er 24 Hrs.	8 Date of Bi			k County
	Funeral Director		216-27-5427	1 ☐ M 2 ☐ X F		20 Yrs.		ays Hours	Min.	8. Date of Bi (Month, Date Apr 16	y, Year)	85 Mar	thplace (State or Foreign ountry)
	D ,		Usual Residence of Decedent		la a	~							,
	faryla ehov	ă	10a. State 10b. County			ty, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 2 No
	28a-f	ect	Maryland Freder	ick	Libe	ertytow	7n 10f. Zip Cod	10			10a Cit	inon of 14th - 4 Co	
	3a or	ā	12054 Main Stree	÷			21762	16			USA	izen of What Co	ountry?
	death ma 2	Jera	11. Marital Status	12. Was Deced	ent Ever in U		Vas Decedent	of Hispanic C	rigin? (Spe	ecify Yes or No		14. Race - Ame	erican Indian,
9	within 72 hours after death with the Maryland ene. than "naturel", or itema 23a or 28a-f ehow ta Madical Examinar must be notified at	Completed by Funeral Director	1 XNever Married 2 ☐ Marrie	Armed Ford ad 1 Tes 2 If Yes, Give	No XI		fYes, sp <i>eci</i> fy (I□Yes 2[X]			Rican, etc.)		Black, Whit	te, etc.
21215-0036	ure!',	d b	3 Widowed 4 Divorced	Year or Dat	es:				·			Specify: Wh:	
7	in 72	olete	15. Decedent' (Specify only highest	grade completed)		(Give	lent's Usual Oc kind of work do DO NOT use re	one durina mo	st of worki	ing	16b. K	ind of Business	/Industry
212	d with Jene.	omp	Elementary/Secondary (0-12)	College (1-4	for 5+)		Traine	_ ′			Equi	ine	
g	e file al Hyg oths	BeC	17. Father's Name (First, Middle, L	ast)				18. Moti	her's Name	(First, Middle	1		
ylai	Menta Menta arked	To	Michael De Lodov	ico					n Bar				
, Maryland	and 2 sh salth and n 27 is m		19a. Informant's Name/Relationsh Michael De Lodov			18621	Tante	rra Wa				Town, State, 2 D 2083	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or itema 23a or 28a -f ehow any injury or other traumatic event, the Medical Examiner must be notified at anote.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp				sition (Name on natory or other ce Crema		Janu 4, 2	-		sville,	Town, State Maryland
Balt	permit. Departr Imports any inj		21. Signature of Funeral Service L	gensee/	6-MO12							P.O. Box	784 Le. MD 21029
П			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that cau	sed the deat	h. Do not ente	or the mode of	dying, such a	s cardiac c	or respiratory a	rrest,	T IX O V T I	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Mov	TIPH	THUW	ries						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a conseq								
		e.	Sequentially list conditions,	b. Due to (or	as a conseq	uence off:							
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									(
ó	ate be executed hysician and the burial-transit	Exa	resulting in death) Last	c. Due to (or	as a conseq	uence of):							
8760,	ate be hysicil he bu	Ical		d									
9	e as t	Med	IF FEMALE:	1									
P.O. Box	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 / es 2 / No 9 / Unknown		h 2 ☐ Fetai it at time of d	I death 3 🗌	Ectopic pregna Other (specify				2	23d. Date of deli Month	ivery Day Year
	that the dended by the solutions	y Ph	Part II. Other significant condition	s contributing to deal	th but not resu	ulting in the un	derlying cause	given in Part	l.	23e. Did t	obacco u	se contribute to	the cause of death?
Records,	n sign	ed by								10	res 2t	No 3□Pr	obably 4 Unknown
000	aw requir is been si 2 should	piet								24a. Was	an	24b. Were au	topsy findings available
Ĕ.		Completed								autor perfo	rmed?	deatha	completion of cause of 2 No
/ita	ysician: The is certificete his director, page	Be (25. Was case referred to medical examiner?					26. Plac	e of Death	Check only o			
5	Physic this c	2	1 XYes 2 □ No			ER/Outpatient	30 004						afy) At scene
Division of Vital	ding After funer	Certification:	27. Manner of Death 1 □Natural 5 □ Pending	N =	Day Year)	28b. Time of Injury	28c. 1	njury at Work? ☐ Yes 2	/	28d. Describe I			1 a 7 A.G.
isi	Attender death	ficat	2 Accident investiga 3 Suicide 6 Could no	t be One Bloom	,	19 57	et, factory, offi		- 7				ral Route Number,
<u>></u>	i Girl	erti	4 Homicide determin	building	etc. (Specify	1)	et, ractory, one	00		City or For	m, State))	cotu
	To the Hospital or Attent within 24 hours after deatt To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Cartifying (Check only one) 2 Madical E	Physician: To the be kaminar: On the basi and manner	st of my knows	wiedge death	occurred at the estigation, in m	e time, date a ny opinion, de	nd place a	nd due to the	(2)100	and manner es	Stated. to the cause(s)
)	To the within To the comple	Me	29b. Signature and title of certifier	Dr. (1/	00	1N)		ense number ME				signed (Month	
2)	ad		30. Name and address of person w	1) [((V) ·	7 .			Penn S	treet				land 21201
	Sta	te	31. Date filed (Month, Day, Year)	32. P	ar's Signa	ture						The state of the s	
3	Registr	ar	JAN 0	3 2006	CARLORS	11.	Logar & .						
DH	MH 17 Rev 1/20	01				- LITTLE - A	The Capable						

ORIGINAL

			1 - For State Registrar	State of Ma	ıryland		artment rtificate			and M		giene Reg. No.	05 4	3591
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Richard John De	eAngelis							2. Date of Dea Decemb	er ^{Day} 28	, <i>ž</i> 865	3. Time of Death 4:00A. _M
	Examir		4a. Facility Name (If not institution, give : 3146 Gracefield 1		3				Location o	g		F	inty of Death	ży
	Funeral Director		5. Social Security Number 6. Security Number 020-24-1262	7. Age	(In yrs. las	3 Yrs.	If Under	Days	If Under a	Min.	8. Date of Birt Month, Day June 24	,1932		ace (State or Foreign achusetts
	Maryland -f show	tor	10a. State 10b. County Maryland Montgomer	y		Town or Lo	cation pring		_				1	0d. Inside City Limits
	n with the	Funeral Director	10e. Street and Number 3146 Gracefield Ro	ad, #103			10f. Zip (Code 0904					of What Coun	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23e or 28e-f show minimity of their transitions are shown and injury of other traumatic event, it is Marical Examinator must be notified at another.		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1≦Yes 2☐N If Yes, Give Year or Dates:	0	1	Was Decede f Yes, speci		spanic Orig , Mexican Specify:	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)		Race - Americ Black, White, o	
Maryland 21215-0036	ed within 72 hogiene.	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)			(Give	lent's Usual kind of work DO NOT use	done di	urina most	of workin	g		f Business/Ind	
/land	uld be file Mental Hy irked oth	To Be (17. Father's Name (First, Middle, Last) Harry	D	eAnge	lis			18. Mothe Dorot		(First, Middle,	Maiden Sum	savag	е
, Mar)	and 2 sho alth and I 27 is ma er trauma		19a. Informant's Name/Relationship (Ty. Richard M. DeAngel			19b. Mailin 50 11	g Address (Erie	Street ar	et Co	or Rural	Route Numbe e Park	r, City or Tov , Mary	wn, State, Zip Land 2	^{Соф)} 0 74 0
Baltimore,	Pages 1 s nent of He int: if item		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Plac cen Metr	ce of Disponetery, cremopoli	sition (Name natory or oth tan C	e of ner place rema	tory		2006 A		on - City or Tor	wn, State Virginia
Balt	permit, Departr Importe any init		21. Signature of Funeral Servic Lice se	900-40 °		B € 44	nalda 100 Po	W ^{ddre} E Wder	ofgw Mil	ardt 1 Roa	Funera ad Belt	l Home sville	PA Mary	land 20705
	Physician :		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused te cause on each line Metas	э.	Do not ente	er the mode	of dying	, such as o	cardiac or	respiratory arr	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	conseque	nce of):								
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a										_
.O. Box 687	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Petal de	eath 3	Ectopic pred Other (spec						Date of deliver Month	y Day Year
rds, P	w requires that been signed t should be deta	ed by PI	Part II. Other significant conditions con Congestive Heart F		t not resulti	ng in the un	derlying cau	nse dineu	in Part I.			bacco use co es 2 XNo		e cause of death?
		Completed by								_	24a. Was a autops perform		b. Were autop prior to com death? 1 \(\subseteq \text{Yes} \)	sy findings available ipletion of cause of
/ita	Physician: The this certificate har all director, page	Be	25. Was case referred to medical examiner?	2.1						of Death	(Check only on			
o	ding Ph h. After th funeral	atlon: To	1 Yes 2 No 27. Manner of Death 14 Natural 5 Pending 2 Accident investigation	ospital: 1 🗍 Inpatien 28a. Date of Injury (Month, Day		VOutpatient Bb. Time of Injury	_	c. Injury a Work?	4 1401	28	e 🎇 Reside Bd. Describe ho			
Divis	i i te	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home (Specify)	ə, farm, stre	et, factory,	office		28	Bf. Location (SI City or Town		mber or Rural	Route Number,
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) **D Certifying Phys 2 Medical Examin	ician: To the best of er: On the basis of e and manner state	examination	edge, death and/or inv	occurred at estigation, is	the time	, date and nion, death	place, an	nd due to the ca	ause(s) and ate and place	manner as sta e, and due to	ted. the cause(s)
.	Withi Som	Σ	29b. Signature and attle of certifier	11 choon	mt)		License 02364					ned (Month, D ber 29,	
	O		30. Name and address of person who con John Stuckey, M.I	D. <i>3</i> /11/0 G ₁	cacef	ield I	Road S	Silve	er Sp	ring	, Maryl	and 20	0904	
	Sta Registr	-	31. Date filed (Month, Day, Year) DEC 3 0 2005	. Aegistrar	's Signatur	App.	K)							

			1 - For State Registrar	State o	of Marylan		artmen <i>rtificat</i>					giene	$f \cup \cup$	managed a	3592	
			1. Decedent's Name (First, Middle	e, Last)							2. Date of Dea	ath			3. Time of Death	_
Н	Physici /Medio		Donald Shel	ton Dawso	n					I	Month Decembe	Day r 2.5		ear	2:23 P N	A
	Examin		4a. Facility Name (If not institution	n, give street and nu	mber)		4b. City,	Town, or	Location				County of			
			Happy Valley 6				Beth					N	lontgo	omer	У	
ı	Funeral		5. Social Security Number	6. Sex 1 🕅 M 2 🗆 F	7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Day	h v, Yea <i>r</i>)	9.	Birthpla Count	ace (State or Foreig	m
	Director		579-50-7260 Usual Residence of Decedent	100	97	Yrs.					August	3, 1	1908	Mi	ssouri	
	land		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10	d. Inside City Limits	s
	Many 1 sh	ţŏ	Maryland Mon	tgomery	Pot	hesda									1 ☐ Yes 2 ☐ No	
	r 28e	rec	10e. Street and Number	egomery	рег	nesua	10f. Zip	Code				10g. Citi	zen of Wha	t Count	N?	_
	h with	DE	Happy Valley 6	789 Goldsh	oro Ros	ad	201	317				U.S.			•	
	deat	ner	11. Marital Status		edent Ever in U.	.S. 13.	Was Deced	lent of Hi	spanic Ori	gin? (Spe	cify Yes or No-		14. Race	America	n Indian,	_
ဖွ	after or ite	by Funeral Director	1 ☐ Never Married 2X Mar	ned 17 Yes	2 No 19	43-	If Yes, spec	_	n, Mexicar Specify:	i, Puerto i	Rican, etc.)		Black, \			
8	hours urei',	d b	3 Widowed 4 Divorced	Year or D	ates: 19	70	100	2 140	эрөспу.				Specify:	MIIT		
Ϋ́	filed within 72 hours after death with the Maryland Hygiene. uther than "naturel", or iteme 23e or 28e-1 show ont, the Medical Examiner must be inclifted at	Completed	15. Deceden (Specify only highe	t's Education st grade completed)		16a. Dece (Give	kind of wor	rk done d	during mos	t of workir	ng	16b. Ki	nd of Busin	ess/Indu	ustry	
4	withir ane. than	d m	Elementary/Secondary (0-12)	College (Exec.	Assis	stani	t to	Pres	ident				nment /	
2	filed Hygie ther		17. Father's Name (First, Middle,			Harry	S. Ti	cumai			ney (First, Middle,		Priva	te		
an	d be ental ced o	To Be	J. W. Dawson						Cora			walder	Julianie)			
Maryland 21215-0036	shoul nd Ma mari	Ĕ	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	na Address	(Street a			Route Numbe	r City o	r Town Sta	te Zin (Code)	_
	nd 2 alth a 27 ic		Virginia J. Day	vson / Wif	e						sboro R	-				7
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 ie marked other than "naturei", or iteme 23e or 28e-1 show any njury or other traumatic event, the Medical Examinar must be notified at once.		20a. Method of Disposition		20b. P	lace of Dispo emetery, crer	sition (Nan	ne of	-310	D	ate		cation - City			Ť
Ĕ	Page nent o		1 ☐ Burial 2 ☒ Cremation 1 ☐ Donation 5 ☐ Other (S		Ciaio	ional			1 '	Janua 200	ary 3,	Fall	s Chu	rch	, Virgini	2
at	permit. Departr Importe any inju		21. Signature of Funeral Service	Licensee	0						ph Gaw	ler'	s Son	s.	Inc.,	CL
<u></u>	89 = 89		Jelle Brof	ef Joseph	14-										o.c. 2001	6
Ш			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	aused the death	n. Do not ent	er the mode	e of dying	g, such as	cardiac or	respiratory ari	est,		í	Approximate nterval Between	
W	Pnysician		Immediate Cause (Final disease or condition	2 Pnet	ımonia									(Onset and Death Days	
E	/Medical Examiner		resulting in death)	-	(or as a consequ	uence of):									T Days	-
	xaniiiio.	<u></u>	Sequentially list conditions,		brovasc		ccide	ent						3	Days	-11
	led sit	nine	if any, leading to immediate cause (Disease or injury	Due to	or as a consequ	uence ot):										
	xecu and al-tra	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a consequ	uence of);								=		
8760,	The law requires that the death certificate be executed to has been signed by the attending physicien and oage 2 should be detached for use as the burial-transit	dicai		d												
89	ificate g phy as the	edic		0.												
Box	leath certific attending p	W/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna		Je					2	3d. Date of	delivery	,	
	deat ne attr	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregn	irth 2 ☐ Fetal ant at time of de		Ectopic pre Other <i>(sp</i> e						Month	D	ay Year	
ت 0	at the de by the a	h Š	9 🗆 Unknown	9□ Unkno												
	res tha iigned I be det	Completed by Physician/Me	Part II. Other significant condition			alting in the ur	nderlying ca	iuse give	n in Part I.						cause of death?	
0.0	w require been sig should t	ted	Congestive Hea	re Fallur	e						1 🗆 Y	es 2XC]No 3[] Probab	oly 4 Unknown	
Hecords ,	a law nasb e 2 st	npie									24a. Was a	:v	prior	to come	y findings available detion of cause of	,
		Š.									perform	ned? 2X□ No	deatl	h? Yes 2	□ No	
Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Otho			(Check only on					
ö		2	1 ☐ Yes 2X No 27. Manner of Death	28a. Date		ER/Outpatien 28b. Time of		A Injuni	4 Nur		e 5 Reside			Specify)		_
o	th. : Afte	tior	1 Natural 5 Pendin 2 Accident investig	g (Mont	h, Day Year)	Injury	М	3c. Injury Work 1 □ Y	? 'es 2 □ N		o. Describe in	JW IIIJUIY	occurred			
DIVISION	of or Attending Patter death. Director: After the in by the funera	ifica	3 ☐ Suicide 6 ☐ Could r	not be 28e. Place	of Injury - At ho	me, farm, stre	et, factory,				of, Location (St	reet and	l Number o	Rural F	Route Number.	-
5	el or A s after oi Dire	Certification:	4 Homicide	buildir	ng, etc. (Specify	")					City or Town	n, State)				
	ospit hour uner		29a. Certifier TCertifyin (Check only 2 Medical	g Physician: To the	best of my know	wledge, death	occurred a	t the time	e, date and	place, ar	nd due to the ca	ause(s)	and manne	as stat	ed.	
	To the Hospitel of within 24 hours affine To the Funerel Discompletely filled in	ledicai		Examiner: On the ba and mann	ner stated.	ion and/or inv	restigation,	in my op	inion, deat	n occurred	d at the time, d	ate and	place, and	due to th	ne cause(s)	
	To To	Σ	29b. Signature and title of certifier	7			29c.	License	number		2		signed (M	/	1	
	50		1 7/2	Wole				0043	029				12/	26/	105	
			30. Name and address of person											- /		
	Sta		Thomas E. Wals	n, M.D.	ZUUU De	nnis A	ve. S	uite	150,	, Sil	ver Spi	ring	, Mar	ylan	d 20902	_
	Registra		DEC 3	0 2005	gistrar's Signat	5. A	Mark Comment									

		-	For State Registrar	State of Ma	-	epartment of Certificate of			l Hygiene	ยยจ	43593		
			Decedent's Name (First, Middle,	Last)				2. Dat	e of Death		3. Time of Death		
	ysicia		RAVIMOND	CARL	Den	4b. City, Town		Mo	2 27		5-1928 M		
	/ledic amin		4a. Facility Name (If not institution,		-	4b. City, Town	, or Location of	of Death	4c	. County of Dea	th		
			1716 Maryland			Shady				nne Aru			
Fun				ATTEL OF F	(In yrs. last birth	Months Day		Min. (Mo	e of Birth onth, Day, Year)	Co	thplace (State or Foreign buntry)		
Dire	ctor	-	577-24-6158 Usual Residence of Decedent		83 ^Y			Sep	t. 8,19	ZZ was	hington DC		
yland	=		10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits		
e Mar	Daill	ctor	MD Anne A	rundel	Shady	Side					1 ☐ Yes 2 X No		
ith the	Sens	Director	10e. Street and Number			10f. Zip Code			10g. Cit	tizen of What Co	ountry?		
ath w	Mat	rai	1716 Maryland A				0764	ining (Connit V	a a a Na	USA 14. Race - Ame	page Indian		
ler de	Chaff	Funerai	 Marital Status Never Married 2 Marrie 	12. Was Decedent E Armed Forces?		13. Was Decedent o		n, Puerto Rican,	etc.)	Black, Whit			
hours af	XAIT	by	3 Widowed 4 □ Divorced	d 1 XYes 2 N If Yes, Give Year or Dates:	1942-45	1 ☐ Yes 22	io Specity:	*		Specify:	White		
72 hor	Ical	ited	15. Decedent's (Specify only highest		16a. [Decedent's Usual Occ	cupation	st of working	16b. Kind of Business/Industry				
ithin it	2 Max	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Give kind of work dor life. DO NDT use reti							
led w Hygier Hertl			12 17. Father's Name (First, Middle, La	act)	M	odel Makeı		er's Name (First,			vernment		
d be fundal be to do to	949) Be	Raymond C. Demp	•				Bessie B					
ire, Maryianto ZIZIO-0050 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23a or 28a-f show	metic	ှ	19a. Informant's Name/Relationship		19b.	Mailing Address (Stre				or Town, State,	Zip Code)		
7 5 d 7 15 g	r trau		Diana Cohen (Da	ughter)	308	Linthicur	n Stree	et, Rock	ville,	MD 2085	1		
s 1 a of Hear item	othe	İ	20a. Method of Disposition		20b. Place of I	Disposition (Name of crematory or other p	1	Date		ocation - City or			
Page nent c	IIV OI		1 X Burial 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Spe		Mary1a	nd Vet. Co	em.	Jan. 6,2	006 Che	1tenham	, MD		
Dallimore, permit. Pages 1 an Department of Heali	any inju		21. Signature of Funeral Service Li	ensee 0		22. Name and Add	tress of Facility	_{ity} eral Hom	e. P.A.				
n %2F	2 9	_	132 9.00	<i>3</i> —		12 Ridg	gely Av	venue, A	nnapoli	s, MD 2			
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	nly one cause on each lin	ιθ.						Approximate Interval Between Onset and Death		
Physic /Med			Immediate Cause (Final disease or condition resulting in death)	_a	1000	RDIAL	IN.	MARC7	im		I HOUR.		
Exam				Due to (or as	consequence of):							
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as a	a consequence of):							
belu: d	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.									
C, exec	urial-tr	Exc	resulting in death) Last Due to (or as a consequence of):										
8 / 6U ate be e	the bu	dicai	,	d									
و الله و	e as	Mec	IF FEMALE:	23c. If yes, outcome of	of pregnancy					23d. Date of de			
BOX Bath cer attendir	for u	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death	3 ☐Ectopic pregnar 5 ☐ Other (specify)				Month Month	Day Year		
i the of y	ched	ysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown									
cords, F.C. wrequires that the de	e deta	by Pr	Part II. Other significant condition				given in Part I	1, 23	e. Did tobacco	use contribute to	the cause of death?		
COLUS w requires been sigr	d blu			DI ABETE.	5				1 ☐ Yes 2	□ No 3□ Pi	obably 4 Unknown		
as ber	2 sho	ompleted	H	/ PERCHOLE	STEROLO	Min.		24	a. Was an autopsy	prior to	itopsy findings available completion of cause of		
	page	Con	′ /					10	performed? Yes 2 No	death? 1 ☐ Yes	2 No		
VITAL MEQ victor: The lav	director,	Be	25. Was case referred to medical examiner?	Linguish				e of Death (Chec	k only one)				
this	ip le	To.	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatie		ALIBITE SEL DON		ursing Home 5	Residence		cify)		
ding I	funer	tion	1 Natural 5 ☐ Pending	(Month, Day		ury W	vork? ☐ Yes 2☐		Sacribo How Inju	ry coodingo			
DIVISION of Attending after death. Director: Atte	by the funeral	fica	3 Suicide 6 Could no	ot be 28e. Place of Inju	ıry - At home, farr	m, street, factory, office	e e	28f. Loc	cation (Street ar	nd Number or R	ural Route Number,		
al or a	filled in t	Certification;	4 Homicide	building, etc	c. (Specity)			Cit	y or Town, State	9)			
DIVISION (To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After	stely fille	Medical C		Physicien: To the best of xeminer: On the basis of and manner sta	examination and								
o the	completely	Me	29b. Signature and title of certifier	01	1 1 1	29c. Lice	ense number		29d. Da	te signed (Mont	h, Day, Year)		
- > -	3		Harvey	Stein	feld		515		12	128/	2005		
			30. Name and address of person w		eath (Item 23a) (T	ype, Print)	131	SHADY	1 510.	E A	0		
	CA-	•	HARVEY 57 31. Date filed (Month, Day, Year)	BINFELD 32. Resistra	ar's Signature	540	DY 51	01 /	70	207	64.		
Re	Sta gistr		DEC 3		we &	book							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierje (1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 27, 2005 11:30 A^M December Leah Anna Dickhaut 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring
If Under 1 Year | If Under 24 Hrs. 1407 Noyes Drive Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2 🕱 F Yrs. 365-18-4030 92 Jan.16,1913 Washington, D.C. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 TNo Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20910 1407 Noyes Drive USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status I □Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Henry Angerman Moore Anna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1407 Noyes Drive Silver Spring Maryland Johanna E. Dickhaut Daughter 20b. Place of Disposition (Name of cemetery, grematory or other place)
Metropolitan
Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/28/2005 Alexandria, Virginia 21. Signat / e / Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition a Cardiopulmonary Arrest resulting in death) Due to (or as a consequence of): b. Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hypertensive Heart Disease that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Par e contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25 Other (Specify)

Physician /Medical Examiner

Examiner

Physician/Medical

þ

Completed

Be ٩

Certification;

cai 298

27

29b. Signature

hd title of certifier

Nasreen Kango, M.D.

31. Date filed (Month, Day, Year)
DEC 2

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

2005 9

Physician

/Medical

Examiner

Funeral

Director

Itams 23a or 28a-f show ner must be putified at

r then "naturel", or Itams the Madical Examiner or

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel; or itan eny injury or other traumatic event. The Medical Examinar once.

Baltimore, Maryland 21215-0036

Director

Funerai

þ

Completed

Be 2

with the Maryland

death ,

attending physician and for use as the burial-tran the signed by the page 2 certificate this

The law requires that the death certificate be executed the Hospital or Attending Physician: Director: After this in by the funeral of death. To the Hospital or Attend within 24 hours after death To the Funeral Director:

P.O. Box 68760

Records,

Division of Vital

II. Other significant conditions	contributing to death but not re	sulting in the underlyin	ig cause given in Part I.		se contribute to the cause of deat No 3 □ Probably 4 □Unk							
				24a. Was an autopsy performed? 1 □ Yes 2 ₩ No	24b. Were autopsy findings ava prior to completion of caus death? 1 \(\text{Yes} \) 2 \(\text{No} \)							
Was case referred to medical			26. Place of	Death (Check only one)	th (Check only one)							
examiner? 1	Hospital: 1 Inpatient 2 (☐ ER/Outpatient 3☐	DOA Other: 4 Nursin	ng Home 5 🔀 Residence (lome 5 X Residence 6 □Other (Specify)							
Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injur	y occurred							
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Place of Injury - At	e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Roi City or Town, State)										

State Registrar

10

DHMH 17 Rev 1/2001

7610 Carroll Avenue #205

29c. License number

29d. Date signed (Month, Day Year,

20912

Takoma Park, Maryland

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 12 Day 31 2005 John Joseph Dilius 6:09 P M /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ocean City Worcester 13703 Lighthouse Ave. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1 / 31 / 1928 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1**X** M 2□F Director 77 Yrs. 142-20-1955 NJ Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location itam 27 is markad other than "natural", or Itams 23e or 28e-f show other traumatic evant, the Medical Evantinar must be notified at 10d. Inside City Limits Director MD Worcester Ocean City 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21842 USA 13703 Lighthouse Ave. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or Itel Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office work Manufacturing 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Michael Dilius Anna Staruti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 59 Fieldcrest Way, Hazlet, NJ 07730 Maureen Greil 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ▼ Burial 2 Cremation 3 Removal from State ö permit. Page Department Important: If any injury or * 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven 1/4/2006 Dagsboro, DE 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 disease, or complications that caused the failure. List only one cause on each line Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Deat Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a Box 68760, physician Physician/Medical as the b IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death ŏ in the past 12 months?
1 Yes 2 No 4□Pregnant at time of death Month Day 5 Dther (specify) Division of Vital Records, P.O. the 9 Unknown ۾ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ ✓ 0 24a. Was an autopsy performed? 2 0 No 1 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? After Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation М 1 ☐ Yes 2 ☐ No Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 / Homicide within 24 hours a To tha Funarel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Amend item#5, perFH, 0853, 3/14/06 TI State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** DAUGHTRY TERRY 1445 PM DECEMBER 31 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner RANDALLSTOWN NORTHWEST HOSPITAL 2164 - 50 - //34 If Under 1 Year | If Under 24 Hrs. | 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 Ø M 2 □ F Min. 57 Yrs. mo, Director FEB. 5, 1948 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show the Medical Exeminer must be notified at MD. BALTIMORE 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12342 BONMOT 21136 USA , or Itams 23a death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 1 No Specify: Black þ 3 ØWidowed 4 □ Divorced "neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MAID WORKER 7 +4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental tomonds EUA DAUGHTRY JAMES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 Is any injury or other trau once. 12342 BONMOT Place Reisterstown KoseHa (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State BAUT. MO. JAN 5, 2005 Cedar Hill Cem 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility S Funeral Home GRRY DOWN IT Werel Home 110 West Journ IT West MA illeis Mu a 23a. Part1. Enter yie disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or which failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician hepatic

Due to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and the burial-transit The law requires that the death certificate be executed Due to (or as a con equence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the attending IF FEMALE esn. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 ∑Unknown 1 ☐ Yes 2 ☐ No page 2 should Be Completed peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No certificate has 1 Yes 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t within 24 hours efter To the Funerel Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number December 31, mo D 0059736 Luctson 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo OLD LOURT ROAD 5401 OEB GRAH NORTHWEST HOSPITAL WATS:N, 32. Registr s Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiette | Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 24, 2005 6:00 p M **Physician** Erhardt Jonathan Wayne /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Columbia Howard Rainleaf Court 8. Date of Birth Dec. 1, 1959 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country)
Washington, DC 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Hours 1**X**1M 2□ F 46 214-76-6166 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b County ral', or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Columbia Howard Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21046 U.S.A. 9827 Rainleaf Court filed withIn 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 11. Marital Status 1X Never Married 2 Married white 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify If Yes, Give Year or Dates: 1978-79 þ 3 Widowed 4 Divorced "natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) union / IBEW electrician 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 Is marked oth any jollary or other traumatic avant 2008. Be Flinn Louise Erhardt, Sr. Warren David 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12468 Sagebush Dr., Lusby, MD 20657 Sheryl Griffith, cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery Jan. 5, 2005 Brentwood, MD 1 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Lic Rausch Funeral Home, P.A., Owings, MD 20736 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final impocardial i unknown **Physician** disease or condition resulting in death) /Medical Tation with Confertive heart failure Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Mapper of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month. Day, Year) 29c. License number 29b. Signature and title of certifier 1)-19252 06

State Registrar

5+1

DHMH 17 Rev 1/2001

32. Registrate Signature

06 | Secure St. Specific

9470 Annapolis Rd., Lanham, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

Jae S. Chung, M.D.,

31. Date filed (Month, Day,

_			1 - For State Registrar	State of Marylar		artment			nd Me		iene	5	43598
	Physic	an	Decedent's Name (First, Middle, Last)						2.	Date of Deat Month	Day	Year	3. Time of Death 2:20p M
	/Medi Exami	cal	Philip 1 4a. Facility Name (If not institution, give s	F. Finelli, S	Sr.	4b. City	Town or	Location of		ec.29,		y of Death	
1	LXaiiii	ici	4846 Park Avenue				thes		Dodin			ontgo	
	Funeral		5. Social Security Number 6. Sex	_ ' ' -	last birthday)	If Under		If Under 24 Hours	4 Hrs. 8. Min.	Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign intry)
	Director		578.26.8968 Usual Residence of Decedent		Trs.					ept.17			eto, Italy
	uyland	_	10a. State 10b. County		ty, Town or Lo								10d. Inside City Limits
	he Ma	Director	MD Montgon	nery E	Bethesd								1 ☐ Yes 2 X No
	with t	Dir	10e. Street and Number 4846 Park Avenue			10f. Zip		016		10	g. Citizen of		ntry?
	death ma 2:	Funeral		2. Was Decedent Ever in U	J.S. 13. y	Was Deced		816 panic Origin	n? (Specify	y Yes or No- an, etc.)		S.A.	can Indian,
36	or Ite		1 ☐ Never Married 2 X Married	Armed Forces? 1 ▼Yes 2 □ No WW I If Yes, Give	T	tYes, speci 1 □ Yes 2		, Mexican, I Specify:	Puerto Ric	an, etc.)		ick, White,	
Ö	72 hours after death with the Maryland "natural", or Itema 23a or 28a-f show ideal Exantirer must be notified at	Completed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:							Speci	- //	hite
215	d within 72 jiene. r than "na r than "na	piet	(Specify only highest grade Elementary/Secondary (0-12)		16a. Deced (Give life. L	kind of worl DO NOT us	i Occupa k done di e retired)	uring most o	of working	1	6b. Kind of E	Business/In	dustry
21	filed with Hygiene other tha	Com	12	College (1-40/ 5+)	Orname	ental	Iro	n Work	ker	Ov	mer D	istri	c Ornamenta Inc.
and	be filed ntal Hyg ad othe avant,	Be	17. Father's Name (First, Middle, Last)						,	irst, Middle, M	aiden Suma		
Maryland 21215-0036	should id Mer marke matic	²	Domenico Fir. 19a. Informant's Name/Relationship (Typ.		19h Mailin	a Address	(Stroot o			Papano		04-4	2.11
	nd 2 salth ar 27 is rrtrau		Phil Finelli, Jr.							ckville		, State, Zip 2085	
Baltimore,	of Head		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	20b. F	Place of Dispos cemetery, crem				Date		0c. Location		
Ë	ment tant: i		* 4 ☐ Donation 5 ☐ Other (Specify)	Ga	te of H	Heaver	n	ļЈа		2006 8			
Bal	permit. Pages 1 and 2 should be fill Department of Heatih and Mental H Important: If item 27 is marked ott any Injury of other traumatic avan once.		21. Signature of Funeral Service License	Don	51	130 W	İscor	nsin A	venu	ph Gawl e NW WD	C 2001		Inc.
8760,	death certificate be executed e attending physician and ior use as the burial-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Metastatic Due to (or as a consequence to (or a))).	uence of):	ate Ca	ancei						Onset and Death Years
O. Box 6	death certifi e attending id for use as	by Physician/Medical	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	I death 3	Ectopic pred						te of delive	ery Day Year
ds, P	og pe	by P	Part II. Other significant conditions cont Aortic Stenosis, L	ributing to death but not res	ulting in the un	derlying cau	use given	in Part I.					ne cause of death?
Record	w requir been si should	letec	Atrial Fibrillatio						- F				abiy 4 🕅 Unknown
	n: The lavificate has	Completed								24a. Was an autopsy performe	ed?	prior to cor death?	psy findings available inpletion of cause of 2 No
₹	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	espital: 1 Inpatient 2	EB/Outpotions	3∏ DOA				heck only one;			
Division of Vital	nding Phy ath. r: After thi e funeral o		27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		c. Injury a Work?	at 2 No	28d.	5 🕅 Residen Describe how	injury occur	er (<i>Specit</i>) red	//
Divis	tal or Atta s after de al Directo ad in by th	27. Manner of Death 1 XNatural 2 \subseteq Accident 3 \subseteq Suicide 4 \subseteq Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? M 1 \subseteq Year 28c. Injury at Work? 28c. Injury at Home, farm, street, factory, office building, etc. (Specify)								Location (Stre City or Town,	et and Numb State)	er or Rura	l Route Number,
	To the Hospitel or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	cian: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inve	occurred at estigation, in	t the time n my opir	, date and p nion, death o	olace, and occurred a	due to the cau t the time, date	se(s) and ma and place,	inner as st and due to	ated. the cause(s)
)	Tor Torn	Σ	29b. Signature and title of certifier **Laward 7 Ca	ellew wo			License r D002	number 6607			l. Date signe ec. 30		
_			30. Name and address of person who comes $Edward \ T \bullet \ Cu$		7625 Wi	scons	in A	venue	Beth	esda, l	MD 20	816	
	Sta Registr	_	31. Date filed (Month, Day, Year) JAN 0 3 200	32. Pegistrar's Signa		with)							

	•	For Amend Item State Registrer	State of Marylan s 23a, 25, 27, 28	d / Departi a-f per Certifi	ment of He ME G852 icate of L	ealth and No. 02/17/06 Seath	lental Hy odnb	giene Reg. No.	005	435	99
		1. Decedent's Name (First, Middle, La	ist)				2. Date of De. Month	ath Day	Year	3. Time of	Death
Physicia		Herbe	ert Roland	Eiker			Decemb			1:45	A M
/Medic Examin		4a. Facility Name (If not institution, gir			. City, Town, or	Location of Death		4c. (County of Death		
Examini	eı	Frederick Memor:			Frederi	ck			Frederio	~l~	
Funeval	_		Sex 7. Age (In yrs.		Under 1 Year	If Under 24 Hrs.	8. Date of Bin	h	9. Birth	place (State o	r Foreig
Funeral Director			18 M 2□F 64	Yrs. Me	onths Days	Hours Min.	July 30	1,194	1 Mary	ntry) land	
511 CO.O.		Usual Residence of Decedent							J-54- J		
Mo m		10a. State 10b. County	10c. Cit	ty, Town or Location	on					10d. Inside Ci	ty Limits
프볼	ģ	Maryland Frederi	ck Fr	ederick						1 🗌 Yes	2 T NO
288	Je C	10e. Street and Number		1	Of. Zip Code			10g. Citiz	en of What Cou	intry?	
38.0	◘	6127 Jefferson BL	VD		21703		U	nite	d State	S	
"naturel", or items 23a or 28a-f show sideal Examination hust be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U	.S. 13. Was	Decedent of His	spanic Origin? (Spin, Mexican, Puerto	ecify Yes or No	- 1	4. Race - Ameri		
	5	1 Never Married 2 X Married	Armed Forces? 1 XYes 2 ☐ No			n, Mexican, Puerto	Rican, etc.)		Black, White		
, E	β	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 🗆	Yes 22 No	Specify:			Specify: Whi	te	
H	ed	15. Decedent's E	Education	16a. Decedent	's Usual Occupa	tion		16b. Kir	nd of Business/fr	ndustry	
- g	Siet	(Specify only highest gi		(Give kind	d of work done d NOT use retired)	uring most of work	ing				
42	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) +2	Marke	ting			Tele	phone Co	ompany	
id other than "natur event, the Madical	Ö	17. Father's Name (First, Middle, Las				18. Mother's Name	e (First, Middle,	Maiden .	Sumame)		
	Be	Herbert Roland E	liker			Grace Zi	mmerman	1			
item 27 le merke other traumatic	은	19a. Informant's Name/Relationship		19h Mailing A	ddross (Stroot a	nd Number or Run			Town State Zi	n Code)	
Iraur		E. Ann Eiker / Wi	, , , ,	_						p 0040)	
item 27 other tr		The second secon				n Blvd, F	Date		cation - City or T	'own State	
		20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 3 (Hemovai irom State	Place of Disposition cometery, cremate							
n y		4 Donation 5 Other (Spec	ify) Fr	ederick					erick,		ıd
important: if any injury or pnce.		21. Signature of Funeral Service Lice	insee			s of Facility Sta					
E = 8		Brolly I show	and a second	162	l Upossi	mitown Pi	ke, Fre	deri	ck, MD	21702	
		23a. Part1. Enterthe mease, or conshock, or heart solure. List on	lications that caused the dear	th. Do not enter th	ne mode of dying	, such as cardiac	or respiratory a	rrest,	1,1,2,000 1,000 1,000	Approximate Interval Bet	e ween
cian		Immediate Cause (Final	GITO SEESSO OIT SEEST IIIIO.	0616 I	ntracra	nial hemo	orrhage			Onset and t	
dical		disease or condition resulting in death)	a Due to (or as a consec	hall 2				-		Luay	2
niner			D _c	KUMONIA-				1		Weel	\$
	<u>-</u>	Sequentially list conditions if any, leading to immediate	b. Due to (or as a consec	A R THE COLUMN TWO IS NOT THE OWNER.	com 1.5		//-	1			
nsit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	R	SOIFATORY-	Failure	CERTIFICATION AP	1 / 615	ICAL EXA	NINER	HWECK	5
al-tra	xa	resulting in death) Last	Due to (or as a consec	quence of):		A MAR	PROVED BY MILE				
the burial-transit	cai					CERTIFICATION					
s the			_ u.								
detached for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregn.	ancy				١,	3d. Date of deliv	JAN.	
for	lar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3 Ect	topic pregnancy her (specify)			-	Month	•	Year
hed	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	3000	Tiel (specify)						
Jetac	P	Part II. Other significant conditions	contributing to death but not re-	sulting in the under	rlvina cause aive	in in Part I	23e. Did t	obacco u	se contribute to	the cause of c	eath?
should be det	و	+ Intracrani	41 Hamaccha	2_	.,		İ	Yes 2[/ Jnknow
onlo	ted	· ±IIII del dill	at Triorriag	<u> </u>							
CI I	Completed by	1. Sc126185					24a. Was		24b. Were aut	opsy findings ompletion of c	
age.	ě	3. Kenal lai	tire-				perfo	rmed)	death? 1 ☐ Yes		
tor.	0	25. Was case referred to medical		16-1		26. Place of Deat	100		-		
director, pag	0 B	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient	3□ DOA Othe	F: 4 ☐ Nursing Ho	me 5 Resi	dence 6	3 ☐Other (Spec	ify)	
eral di	Ë	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury	at	28d. Describe				
funer	Ę	1-☑Natural 5 ☐ Pending 2 ☑ Accident investigate	on 12/04/2005	10:00	Work 1□\	?? ∕es 2. (2 X No	fall	on i	ce on d	rivewa	y
in by the	E C	3 Suicide 6 Could not	be 28e. Place of Injury - At h	ome, farm, street,	factory, office		28f. Location (Street and	d Number or Ru	ral Route Num	ber,
i E	Certification:	4 Homicide	building, etc. (Speci	(h) at ho			127° Je	fers	on Blvd	.,Fred	erio
completely filled in by the funeral director, page		29a. Certifier 1 Certifying F	Physicien: To the best of my kn	owledge, death on	curred at the tim	e, date and place	and due to the	cause(s)	and manner as	stated.	
completely filled in by	Medical	(Check only 2 Medical Exe	eminer: On the basis of examination and manner stated.	ation and/or invest	tigation, in my op	oinion, death occur	red at the time,	date and	place, and due	to the cause(s	.)
Jdwc	Me	29b. Signature and title of certifier			29c. License	number		29d. Date	e signed (Month	, Day, Year)	
. 8		- / 1	M.D.		חותם	55793			12/3/10:	5	
									-10110-		
· ·		30. Name and address of person wh	8.6 4 1 6 2	m 23a) (Type, Prir	(Lirech	K. Men	n M. D				
		21 Date filed (Month 2: V	Memorial Hospita	1	- O(1 C)	, ICIN)				
	ite	31. Date filed (Month, Day, Year)	32. Regitrar's Sign	atuie							

DHMH 17 Rev 1/2001

•			For State Registrer	State of Ma	aryland		artmer rtificat			and M		giene (5	360	0 (
10			1. Decedent's Name (First, Middle, Las	1)							2. Date of De. Month	ath Day	Year	3. Time o	f Death
10 11 /2	Physici		John	Walter		Frey,		Jr	•		Decembe		2005	9:15	a M
	/Medic Examin		4a. Fecility Name (If not institution, give	street and number)			4b. City,	Town, or	Location o	of Death		4c. Coun	ty of Death		
100			Calvert Memorial	Hospital			Pr	ince	Frede				lvert		
*	Funeral Director	-050	5. Social Security Number 6. Se	7. Age	e (In yrs. la	a <i>st birthday)</i> Yrs.	If Under Months	Days	If Under a	24 Hrs. Min.	8. Date of Bird (Month, Da Oct 10	h y, Year) • 1921	9. Birthi Cou	olace (State ontry) Sylva	or Foreign nia
整	დ		Usual Residence of Decedent 10a. State 10b. County			, Town or Lo	cation						1	10d. Inside C	ity Limits
	Maryla I-f ahov	tor	MD Calve	ert	Too. Only	, , , , , , , , , , , , , , , , , , , ,		nting	gtown						2 X No
	r 28	lrec	10e. Street and Number				10f. Zij	Code				10g. Citizen o	f What Cou	ntry?	
	h wit	a D	629 Small Reward	Road				206	539			1	USA		
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Ptygene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Madical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 XYes 2 □ N If Yes, Give Year or Dates:	10		Was Dece If Yes, spe 1 Yes		spanic Orig n, Mexican Specify:	gin? (Spe n, Pu er to f	cify Yes or No Rican, etc.)	Spec	ace - Ameri lack, White, cify: who	etc.	
21215-0036	n 72 hou "natura	Completed I	15. Decedent's Ed (Specify only highest grad	ucation de <i>completed)</i>		16a. Dece		ork done d	furing most	t of workir	ng	16b. Kind of	Business/In	dustry	
12	within iene.	d mo	Elementary/Secondary (0-12)	Coltege (1-4or 5	i+)	mana	ager					coun	try c	Lub	
<u>0</u>	Hyg other	BeC	17. Father's Name (First, Middle, Last)	-			· · · · · · · · · · · · · · · · · · ·		18. Mothe	r's Name	(First, Middle,	Maiden Sum	ame)		
Maryland	Mental arked o	To B		rey, Sr.		1				ette	Н.		Hirs		
Nar	2 sh and ts m		19a. Informant's Name/Relationship (7	ype, Print)			-				Route Numbe Hunti				
	of Heelth a item 27 is		Pat A. Beyer 20a. Method of Disposition		20b. Pl	lace of Dispo			swaru		ate	20c. Location			
0	Pages 1 nent of h unt: if ite ury or ot		1 ☐ Burial 2 X Cremation 3 ☐		CE	metery, crei	matory or	other plac						ia, VA	
Baltimore,	t. Pa rtmer rtant njury		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		Met				s of Facilit		70-00	NIC.	Xariar.	La, VA	<u> </u>
Ba	Depa Impo any i		Illian R	Gm						-	e, P.A.	, Owin	gs, M	207	36
)	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. Due to (or as	ne. <u>UM</u> a consequ	owa uence of):	ter the mo	de of dyln	g, such as	cardiac o	r respiratory a	rest,		Approxima Interval Be Onset and	tween
8760,	death certificate be executed e attending physicien and of for use as the burial-transit	dical Examiner											<i>U</i>		
O. Box 6	death certific e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal	death 3	⊒Ectopic p ⊒ Other (s						Date of deliv	-	Year
ds, P.	es po	by	Part II. Dther significant conditions of	ontributing to death b	ut not resu	ulting in the u	inderlying	cause giv	en in Part I.		23e. Did t	obacco use co res 2 No		he cause of bably 4	
Vital Records,	9 4 9	Completed									24a. Was autor perfo		D. Were auto prior to co death? 1 \(\text{Yes}	opsy findings emptetion of a	available cause of
ita	ilcian: Th certificate rector, pag	Be C	25. Was case reterred to medical examiner?						26. Place	of Death	(Check only o	one)			
	Physician: rthis certificant all director,	10	1 ☐ Yes 2 No	Hospitat: Inpatie	ent 2 🗆	ER/Outpatie	nt 3 D	OA Oth	er: 4 □ Nu	ursing Hon	ne 5□Resi	dence 6 🗆 C	ther (Speci	fy)	
on of	5 e		27. Manner of Death CNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	of M	28c. Injun World 1 🔲	/at k? Yes 2□		28d. Describe	how intury occ	urred		
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined	1	ury - At ho c. (Specify	ome, farm, st	reet, facto	ry, office	.,.	2	28f. Location (City or To	Street and Nui vn, State)	mber or Rur	al Route Nur	nber,
	Mospitu 124 hours Funere letely fille	dlcal		ysician: To the best niner: On the basis o and manner st	f examina										s)
	within To th	Me	29b. Signature and title of certifier	7			29	c. Licens	e number			29d. Date sign	ned (Month,	Day, Year)	
			Meur Bris	4 MD			1	1006	047	5		12/	22/1	25	
	r- 1 1		30. Name and address of person who							- ^		-0		24.0	
	541		TEREUA BUSH	MD 10		OSPI	TAL	ROI	D1	PRI	WCE	PRET	A111	4 MI)
	St Regist	ate rar	31. Date filed (Month, Day, Year) DEC 2	32. Registr	Signa Signa	ture #	Col	we se						200	76

			For State Registrar	State of Maryla		artment of rtificate o			giene () (05 43601
200	Physici /Medic		1. Decedent's Name (First, Middle, Last Samuel J F	onte, Dr.				2. Date of De Month	30 2	Year 3. Time of Death
)	Examin	er	4a. Facility Name (If not institution, give Cocs tal Hospice, 5. Social Security Number 6. Se	it the Lake	. last birthday) Yrs.	4b. City, Town If Under 1 Ye Months Day		rs. 8. Date of Bir n. (Month, Da	th ly, Year)	9. Birthplace (State or Foreign
	Director		218 28 7614 ') Usuat Residence of Decedent 10a. State 10b. County		ity, Town or Lo	cation		June 7	, 1934	Maryland 10d. Inside City Limits
	the Mary	rector	Maryland Worcest 10e. Street and Number	er O	cean Ci	ty 10f. Zip Code	9		10g. Citizen of	1 Yes 2 □ No What Country?
9	be filed within 72 hours after death with the Maryland ital hygiene. Id other then "netural", or iteme 23a or 28a-f show event, the Medical Exercitive must be published at	/ Funeral Director	1215 Boardwalk 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 □ Wes 2 □ No If Yes, Give		2184 Was Decedent of Yes, specify C	of Hispanic Origin? uban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	Bla	ce - American Indian, ick, White, etc.
21215-0036	- 20	Completed by	3 Widowed 4 Divorced 15. Decedent's Edi (Specify only highest grade) Elementary/Secondary (0-12)	Year or Dates: location le completed) College (1-4or 5+)	16a. Deceo (Give life. I	dent's Usual Oc kind of work do DO NOT use ret	cupation ne during most of w ired)	vorking	16b. Kind of B	Business/Industry
Maryland 2	should be filed withir and Mental Hygiene. I marked other then umatic event, the Mental Hygiene.	Be	17. Father's Name (First, Middle, Last) Samuel Joseph Fon	te, Sr.	Keal	Estate I		ame (First, Middle,		
	12. har 7 le		19a. Informant's Name/Relationship (7) Joan Marie Fonte	rpe, Print)			alk Ocea	Rural Route Numbe	er, City or Town	
Baltimore,	Peges 1 and lent of Healt int: If item 2 ry or other		20a. Method of Disposition 1 Burial 2 Coremation 3 4 Donation 5 Other (Specify)	Removal from State	Place of Dispo cemetery, cren	sition (Name of natory or other p		Date	20c. Location Frankfo	- City or Town, State
Balti	permit. Peges i Department of H Important: if its eny injury or ot once.		21. Signatural Interview ervice Licens	Pinhas.	22	. Name and Add		108	William	n St
58760,	Physician /Medical Examiner	dical Examiner	23a. Parfi. Enter the disease, if comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.) Due to (or as a consect.) Due to (or as a consect.)	quence of): Quence of):	10N/	tying, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
P.O. Box 6	death certif ie attending ed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	at death 3 □	Ectopic pregnal Other (specify)				ate of delivery onth Day Year
	law requires that the de: as been signed by the a r 2 should be detached fo	by	Part II. Dther significant conditions ∞	ntributing to death but not re	sulting in the ur	nderlying cause	given in Part I.		obacco use con Pes 2 No	tribute to the cause of death? 3 Probably 4 Unknown
al Records,	The te h	e Completed	Of Western television to residual					1 Yes	rmed?	Were autopsy lindings available prior to completion of cause of death? 1 Yes 2 No
ion of Vital	ding Phys h. After this funeral di	To B	27. Manner of e 1 Pending 2 Accident investigation	lospital: Inpatient 2 [28a. of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. In	Other: 4 Nursing	Home 5 Residue 128d. Describe to		
Division	를 를 들	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	nome, farm, stre	eet, lactory, office	ce .	28f. Location (S City or Tox		ber or Rural Route Number,
	To the Hospital or within 24 hours efter To the Funerel Dirac completely filled in I	edical	29a. Certifier Certifying Phy (Check only one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the restigation, in m	time, date and pla- y opinion, death oc	ce, and due to the curred at the time,	cause(s) and made,	anner as stated. and due to the cause(s)
)	To the Within To the Comp	M	29b. Signature and title of certifier		ace	- 7	ense number	8	29d. Date signe	d (Month, Day, Year)
イ	6+1 Sta	te	30. Name and address of person who con the control of the control	ISAACS 32. Registrar's Sign	THE	ECS,	HEAT	> Site	E 730	PEY MAIN ZIED
35	Registr	ar	JAN U 3 20	106 Marian	1 do	casti 1				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Stata Registrar Amend Item #12&19a Per FH G**854rtificate of De**path Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** 10:00 27 2005 Arthur David Fried December /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 8019 Aberdeen Road Bethesda Montgomery If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days **Funeral** Hours 10XM 2□F 61 Director New York 075-36-6850 May 20 1944 Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene, and His marked others, or items 23a or 28e-f show ant: if item 27 is marked other than "naturel, or items 23a or 28e-f show up or other traumatic event, the Medical Exerting must be notified at ury or other traumatic event, the Medical Exerting must be notified at 1 ☐ Yes 2 ☐ No Director Montgomery Bethesda 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8908 Grant Street 20814 United States Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever 1966-11. Marital Status 1⊠Yes 2□No 1967 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: If Yes, Givo Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 5+ Budget Officer Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Morris Fried Minna Kurtz Jan dromant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy D. Fried, Spouse 8908 Grant Street, Bethesda, MD 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition v injury or Department of importent: if it ty⊒Burial 2 ☐ Cremation 3 ☐ Removal from State 01-03-2006 | Arlington, VA Arlington Natl. Cem. ^¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home Inc. 21. Signature of Fareral Service Ligense any. 11800 New Hampshire Ave Silver Spring MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 12 Years Chronic Lymphocytic Leukemia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit ed by the attending physicien and detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 3 Probably 4 Unknown 1 ☐ Yes 2 🛣 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□ No certificate 2**XX**No 1 Tes Physicien: funeral director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Daughter' Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 2 No 6 Other (Specify) 2 1 Yes 2 ER/Outpatient 3 DOA Home this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours after death Funeral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ٥ Myomo D23308 December 29, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

DHMH 17 Rev 1/2001

Registrar DEC 3 0 2005

31. Date filed (Month, Day, Year)

Victor M. Priego, MD

6420 Rockledge Drive #4100 Bethesda, MD 20817

		State Registrar		Maryland / Depa <i>Ce</i>	rtificate of			Re	g. No.	15	43603
nysicia Medic	ın	Decedent's Name (First, Middle, Sila	Last)	Fillmann			De	Data of Death Month ecember	26, 2		3. Time of Death 12:47P
kamine	er	4a. Facility Name (If not institution,		^{er)} #3D	4b. City, Town,				4c. Count		
		3510 Forest Ed		Age (In yrs. last birthday)	Silver	-		Date of Birth		1tgom	
al or		579 58 4540	1 M 204	72 Yrs.	Months Days		Min.	Date of Birth (Month, Day, une 10,	1933	B	nplace (State or Foreig untry) razil
	-	Usual Residence of Decedent 10a, State 10b. County		10c. City, Town or Lo	ocation	-					10d. Inside City Limit
once.	5		070 FI	Silver S							1 ☐ Yes 🌠 N
	20	Maryland Montg	Omery	DITAGE 3	10f. Zip Code			10	g. Citizen of	What Co	untry?
		3510 Forest Edge	Drive #3D		209	906			USA		
	Funerai	11. Marital Status	12. Was Decede		Was Decedent of If Yes, specify Cul	Hispanic Orig	gin? (Specif	y Yes or No-		ce - Amer	rican Indian,
	F	1 ☐ Never Married 2 ▼ Marrie		™ No	1 ☐ Yes 2 1 No		, 1 401(0 11(Zari, 610.)		fy: Wh	
	d by	3 Widowed 4 Divorced	Year or Date	os:							
ł	Completed	15. Decedent's (Specify only highest	s Education grade completed)	16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most	of working	1	6b. Kind of B	3usiness/l	Industry
1	d d	Elementary/Secondary (0-12)	College (1-4	or 5+)	ctical N				Т	lospi	+a1
1		17. Father's Name (First, Middle, L	ast)	IIa	CCICAL IN		r's Name (F	First, Middle, M			····
-1	To Be	Joventino Alves	Moura			Otil1	lia I:	zabel D	aSilva	1	
	F.	19a. Informant's Name/Relationshi		19b. Maili	ng Address (Stree	t and Number	r or Rural F	Route Number,	City or Town	, State, Z	Tip Code)
		William B. Fill	mann / Hus	hand 3510	Forest	Edge D	rive	#3D S+1	WOT ST	rino	,MD 20906
2		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other pla		Date	9 2	0c. Location	- City or	own, State
X		1 urial 2 Cremation : 4 Donation 5 Other (Sp.		MD Veter	-		1/3/2	006 C	helter	nham,	Maryland
ġ		21. Signature of Funeral Service L			2. Name and Addr						
ouce	+	tower.	- New	Dune 1	1800 New	Hampsl	hire .	Ave Sil	ver Sp	ring	, MD 20904
		shock, or weart failure. List o		Sed the death. Do not en	ter the mode of dy	ing, such as o	cardiac or r	espiratory arres	st,		Approximate
	er	Immediate Cause (Final disease or condition resulting in death)	aMulti; Due to (or	sed the death. Do not en h line. ple Myeloma as a consequence of): as a consequence of):	ter the mode of dy	ing, such as c	cardiac or r	espiratory arres	st,		Approximate Interval Between Onset and Death
	cal Examiner	Immediate Cause (Final disease or condition	aMulti Due to (or b Due to (or	as a consequence of):	ter the mode of dy	ing, such as c	cardiac or r	espiratory arres	st,		Interval Between
al er	cal	Inimedial Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Multipue to (or b. Due to (or c. Due to (or d. 23c. If yes, outco	as a consequence of): as a consequence of): as a consequence of): me of pregnancy 1 2 Fetal death 3f 1 at time of death 5	□Ectopic pregnan: □ Other (specify)		cardiac or r	espiratory arres	23d. Da	ate of delif	Interval Batween Onset and Death
al er	cal	Immediat Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	a. Multipue to (or b. Due to (or c. Due to (or d. 23c. If yes, outco 1 Live birth 4 Pregnare 9 Unknow	as a consequence of): as a consequence of): as a consequence of): me of pregnancy 1 2 Fetal death 3 { 1t at time of death 5 {	□Ectopic pregnan. □ Other (specify)	cy			23d. Da	onth	Interval Batween Onset and Death
!	by Physician/Medical	Immediat Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	a. Multipue to (or b. Due to (or c. Due to (or d. 23c. If yes, outco 1 Live birth 4 Pregnare 9 Unknow	as a consequence of): as a consequence of): as a consequence of): me of pregnancy 1 2 Fetal death 3 { 1t at time of death 5 {	□Ectopic pregnan. □ Other (specify)	cy		23e. Did toba	23d. Da	onth	Interval Batween Onset and Death
al er	by Physician/Medical	Immediat Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	a. Multipue to (or b. Due to (or c. Due to (or d. 23c. If yes, outco 1 Live birth 4 Pregnare 9 Unknow	as a consequence of): as a consequence of): as a consequence of): me of pregnancy 1 2 Fetal death 3 { 1t at time of death 5 {	□Ectopic pregnan. □ Other (specify)	cy		23e. Did toba 1 ☐ Yes 24a. Was an autopsy perform	23d. Da Mi	onth atribute to 3 Pro Were autiprior to cideath?	Interval Batween Onset and Death very Day Year the cause of death?
	Be Completed by Physician/Medical	Immediat Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	a. Multipue to (or b. Due to (or c. Due to (or d. 23c. If yes, outco 1 Live birth 4 Pregnare 9 Unknowns contributing to death	as a consequence of): as a consequence of): as a consequence of): me of pregnancy 1 2 Fetal death 3 that time of death 1 h but not resulting in the consequence of	□Ectopic pregnan. □ Other (specify) underlying cause g	cy iven in Part I. 26. Place	of Death ((23e. Did toba 1 Yes 24a. Was an autopsy perform 1 Yes 2 Check only one	23d. Da Mi	onth atribute to 3 \(\text{Pro} \) Were autiprior to c death? 1 \(\text{Yes} \)	Interval Batween Onset and Death very Day Year the cause of death? bably 4 Unknow topsy findings available completion of cause of
l r	To Be Completed by Physician/Medical	Inimedial Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Multipue to (or b. Due to (or c. Due to (or d. 23c. If yes, outco 1 Live birth 4 Pregnare 9 Unknowns contributing to deat	as a consequence of): as a consequence of): as a consequence of): me of pregnancy 1 2 Fetal death 3(at time of death 5(n th but not resulting in the unit of the consequence of the consequence of):	□Ectopic pregnan. □ Other (specify) inderlying cause g	cy iven in Part I. 26. Place ther: 4 🗆 Nur	of Death (Crsing Home	23e. Did toba 1 Yes 24a. Was an autopsy perform 1 Yes 2 Check only one	23d. Da Mi	onth atribute to 3 Pro Were autorious death? 1 Yes her (Special Special Interval Batween Onset and Death very Day Year the cause of death? bably 4 Unknow topsy findings available completion of cause of	
al er	To Be Completed by Physician/Medical	Inimedial Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Multi Due to (or b. Due to (or c. Due to (or d. Live birth 4 Pregnar 9 Unknow ns contributing to deal	as a consequence of): as a consequence of): as a consequence of): me of pregnancy 1 2 Fetal death 3(at time of death 5(n th but not resulting in the unit of the consequence of the consequence of):	□Ectopic pregnani □ Other (specify) Inderlying cause g Int 3□ DOA Int 3□ DOA Int 28c. Ing	cy iven in Part I. 26. Place ther: 4 🗆 Nur	of Death (Crsing Home	23e. Did toba 1 Yes 24a. Was an autopsy perform 1 Yes 2 Check only one	23d. Da Mi	onth atribute to 3 Pro Were autorious death? 1 Yes her (Special Special Interval Batween Onset and Death very Day Year the cause of death? bably 4 Unknow topsy findings available completion of cause of	
an eal er	To Be Completed by Physician/Medical	Inimedial Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Multi Due to (or b. Due to (or c. Due to (or d. Due to (or d. Pregnar 9 Unknow ns contributing to deat Hospital: 1 Inp 28a. Date of (Month, atlon ot be 28e. Place of	as a consequence of): as a consequence of): as a consequence of): as a consequence of): me of pregnancy n 2 Fetal death 3 (at at time of death 5 (at at time of death 5 (at at time of death 5 (at at time of death 5 (at at time of death 5 (at at time of death 5 (at at time of death 5 (at at time of death 5 (at at time of death 5 (at at time of death 5 (at at time of death 5 (at at time of death 5 (at at time of death 5 (at at time of death 5 (at at time of death 5 (at at time of death 5 (at at at	DEctopic pregnant Other (specify) Inderlying cause g	cy 26. Place ther: 4 □ Nur uny at ork? □ Yes 2 □ N	of Death (trising Home 286	23e. Did toba 1 Yes 24a. Was an autopsy perform 1 Yes 2 Check only one 3 Resider d. Describe how	23d. Da Mi Mi Acco use con S No 24b. ed? Acco use 6 Otto winjury occur injury occur and Num.	onth 3 Pro Were auli prior to c death? 1 Yes her (Specified)	Interval Batween Onset and Death very Day Year the cause of death? bably 4 Unknow topsy findings available completion of cause of
al er	Be Completed by Physician/Medical	Initimedial Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	A. Multi Due to (or b. Due to (or c. Due to (or d. 23c. If yes, outco 1 Live birtl 4 Pregnar 9 Unknow Hospital: 1 Inp 28a. Date of (Month, attorn of be 28e. Place of building	as a consequence of): as a consequence of):	DEctopic pregnand Other (specify) of Section 1 1 28c. Into W. M. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	cy 26. Place ther: 4 Nur uny at ork? Yes 2 N	of Death (0 rsing Home 280 No 281 d place, and	23e. Did toba 1 Yes 24a. Was an autopsy perform 1 Yes 2 Check only one 5 Resider d. Describe how	23d. Da Milaco use con s No 24b. acco use con s No 24	were au Were a	Interval Batween Onset and Death Very Day Year the cause of death? bably 4 Unknow topsy findings available completion of cause of 2 No sify) Val Route Number,

DHMH 17 Rev 1/2001

State

Registrar

Joseph Kaplan, M.D.
31. Date filed (Month, Day, Year)

DEC 3 0 2005

18111 Prince Philip Drive Olney, Maryland

70832

State of Maryland / Department of Health and Mental Hygiene 0 05 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** December 22 2005 Fochett 0340 Dorothy Mae /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Hours 1 ☐ M 2 🛱 F 26,1924 Washington DC June Director 577-24-0159 81 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "naturel", or Iteme 23s or 28s-f show Its Medical Examinar must be notified at 1 ☐ Yes 2 No Funeral Director MD Prince Georges Cheverly 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2717 Belleview 20785 USA filed within 72 hours after death in Hygiene. Hygiene. kther than "naturel", or Iteme 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXIvo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White þ 3XXWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Depentment of Heelth and Mental Hygiene Important: if Item 27 Is marked other tha eny Injury or other traumatic event, Ital 2008. 12 Bookkeeper Accounting 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lilly Wheeler William Love 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 672 Teton Drive, Lothian, MD 20711 Steven Fochett (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-28-2005 Cedar Hill Cemetery Suitland, MD 21. Signature of Funeral Service Licent 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 21799 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 ician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f Division of Vital Records, P.O. Physi 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificete has autopsy 2 No 2 1 Tyes 1 Yes or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 200 No 1 Propatient ٩ 1 Yes 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After in 24 hours after the control of the Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and lille of certifier 22 05 who completed cause of death (Item 23a) (Type, Print) 30. Name and aldress of person 0 32. degistrar's Signature 31. Date filed (Month, Day, Year) State DEC 3 0 Registrar 2005

		For State	State of Ma	arylan		artment of I	Health and N		jiene	15	4361	05
7/家 家門		Registrar 1. Decedent's Name (First, Middle, Las	st)					2. Date of Dea	th		3. Time of	Death
Physicia	เก		R.	Forr	ell, S	r		Decembe	Day	2005	1337	N
/Medic	_	4a. Facility Name (If not institution, give		rell	E11, D		or Location of Death	1		y of Death	1	
Examin	er	Anne Arundel Me		er			polis			Arun		
-	1000	5. Social Security Number 6. S			last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day			place (State ontry)	or Foreig
Funeral Director			X MM 2□ F	76	Yrs.	Months Days	Hours Min.	Jan. 4,			Virgi	
ow ow	Ì	10a. State 10b. County		10c. City	y, Town or Lo	ocation					10d. Inside C	ity Limits
Man,	to	MD Anne A	rundel	R	iva						1 Tes	2 X) No
r 288	Director	10e. Street and Number				10f. Zip Code		1	10g. Citizen o	What Cou	ntry?	
3a o		2694 Pinecrest D	rive			2114	0		USA			
death ms 2	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Decedent of	Hispanic Origin? (Sp ban, Mexican, Puert	pecify Yes or No-	14. Ra	ice - Amen	can Indian,	
after or ite		1 Never Married Married	1 ☐ Yes 2🛣 1			1 ☐ Yes 2XXNo		o moan, etc.)			hite	
ol', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 Hes ZLING	э эрөспу:		Spec	ny: W	III	
72 ho	Completed	15. Decedent's Ed (Specify only highest gra	fucation		16a. Dece	dent's Usual Occu	ipation a during most of work	kıng	16b. Kind of	Business/Ir	ndustry	
thin 7	ğ.	Elementary/Secondary (0-12)	College (1-4or 5	5+)	lite.	DO NOT use retire	e during most of work ed)					
od wil	5		11		Capta	in			Commer		Airlin	ıe
be filed within 72 hours after death with the Maryland Ital Hyglene. Id other then "naturel", or items 23a or 28a-f show event, the Medical Examinat must be notified at	Be (17. Father's Name (First, Middle, Last,					18. Mother's Nam	ne (First, Middle,	Maiden Suma	ime)		
uld b Venti rked tic e	ည	Walter B. Ferrel	1		,		Thelma D	eLung				
s ma		19a. Informant's Name/Relationship (Type, Print)		19b. Maili	ng Address (Stree	at and Number or Ru	ral Route Numbe	r, City or Tow	n, State, Zi	p Code)	
and alth		Charlene B. Ferr	ell (Wife)	_			st Drive,		D 2114	0		
of He item		20a. Method of Disposition 1 Burial 2XXCremation 3	Dames of from State	20b. P	lace of Disponentery, cre	osition (Name of matory or other pla	ace)	Date	20c. Location	- City or T	own, State	
Page nent nt: if		4 □ Donation 5 □ Other (Specif		Me	tro Cr	ematory	12-2	9-2005	Baltim	ore,	MD	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at once.		21. Signature of Funeral Service Lice	200		2:	2. Name and Addr Hardest 12 Rido	ess of Facility y Funeral ely Avenu	Home, P	A.	MD 21	401	
		23a. Part I. Enter the disease, or com	plications that caused	the deat	h. Do not en						Approximat Interval Bet	te tween
Dhysisian		shock, or heart failure. List only Immediate Cause (Final	one cause on each if		NTA						Onset and	
Physician /Medical		disease or condition resulting in death)	a. Due to for ac	2.000000	uence of):					-		
Examiner			TCC	H1=1V	116 (ARDIO	MYOPAS	THY				
,	e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseq	uence of):		MYOPAS Y DIGE					
nsit	듣	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ARTER	Y DICE								
rate be executed hysicien and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as	a conseq	uence of):							
ate be ex hysicien the buria			d									
icate phys s the	dical		0									
The law requires that the death certific ate has been signed by the atlending p page 2 should be detached for use as 6	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregna	incy				23d. D	ate of deliv	erv	
atten for u	iar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			□Ectopic pregnand □ Other (s <i>pecify</i>) □	су			lonth	,	Year
that the de ed by the detached	ysi	1 Yes 2 No 9 Unknown	9□ Unknown									
that the ed by detac		Part II. Other significant conditions of	ontributing to death b	ut not res	ulting in the u	inderlying cause g	ven in Part I.	23e. Did to	bacco use co	ntribute to	the cause of	death?
sign d be	dby	DEMENTA						1 🗆 Y	es 2 🗆 No	3 Pro	bably 4 💢	Unknow
w requires that s been signed b should be det	Completed	11701						240 1450	245	Wasa sut	anny findings	avadabl
e law	dr.	44114						24a. Was a autop perfor	sy	prior to co	opsy findings ompletion of c	available ause of
	S								25 No	1 🗆 Yes	M2N0	
Attending Physician: Thir death: The coordinate ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Lleasitali					th (Check only or	ne)			
Physic this c	2	1 ☐ Yes 2 No	Hospital:		ER/Outpatie	III JEZIDON		ome 5 Resid			ify)	
ing F Viter uner	0	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury	W	ork?	28d. Describe h	ow injury occi	irred		
tend eath tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 No	00()			10-1-1/-	
or At fler d lirect n by	Certification:	4 Homicide determined		ury - At ho c. (Specif	ome, tarm, st y)	reet, factory, office	•	28f. Location (S City or Tow		wer or Hui	ai Houle NUN	iuer,
urs a												
Hosp 4 hot Fune ely fi	ica	(Check only 2 Medical Exer	nysicien: To the best miner: On the basis of	f examina	wiedge, deal ition and/or in	th occurred at the evestigation, in my	time, date and place opinion, death occu	, and due to the or rred at the time, o	ause(s) and r date and place	nanner as : , and due !	stated. to the cause(s	s)
To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	29b. Signature and title of certifier	and manner st	at00.		29c Licer	nse number		29d. Date sign	ed (Month	Dav. Year)	
Twit or or	_	29b. Signature and title of certainer	N.L.		/		05202		12	127	100	_
		PIAMAIA	1000		~				1	/	100	

DHMH 17 Rev 1/2001

State Registrar

122 Depense hishway

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROMERO

MARIA

31. Date filed (Month, Day, Year)

DEC 3 0 2005

			For State Registrar	State o	f Maryland		artment of H tificate of I		nd Me		iene eg. No.	05	43606
	Dhusisi		1. Decedent's Name (First, Middle, La						2.	Date of Dea Month	Day	Year	3. Time of Death
	Physici /Medic		Wi	lson :	Frnakli	n G	ott			ec 2	1	2005	1235P M
	Examin	er	4a. Facility Name (If not institution, giv				4b. City, Town, or Leonard		Death			ounty of Dea	
	4	7 %	St. Mary's Ho		7. Age (In yrs. lasi	t birthday)	If Under 1 Year	If Under 24	Hrs. 8.	Date of Birth			rthplace (State or Foreign
P	Funeral Director			X M 2□F	71	Yrs.	Months Days	Hours	Min.	(Month, Day, ug 5	Year)	0	ryland
	ס		Usual Residence of Decedent							ug J			
	arylan	_	10a. State 10b. County		10c. City, T								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Sa-1 o	Director		Mary's	1	-eom	ardtown				0- 011	n of What C	
	with the	급	10e. Street and Number				10f. Zip Code						
	eath	erai	Cedar Lane 11. Marital Status	12. Was Dece	edent Ever in U.S.	13. \	20650		n? (Specif				tates erican Indian,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, Ite Medical Exacult	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed For 1 Tyes If Yes, Given Year or D	orces? 2 ∏ No ve X		Was Decedent of Hi f Yes, specify Cuba I □ Yes 2 □ 🔏		Puèrto Ric	án, etc.)	Sį	Black, Wh Black, Wh	
9	2 hou		15. Decedent's E		1		dent's Usual Occupa		f working		16b. Kind	of Busines:	s/Industry
21215-0036	within 7 ene. than "n	pie	(Specify only highest gra Elementary/Secondary (0-12)	College (1	1-4or 5+)	life.	kind of work done o DO NOT use retired)	ii working				
2	e filed within al Hygiene. I other than vent, I'le Mai	Completed	unknown 17. Father's Name (First, Middle, Last			far	ner	40 14-4-4-		First, Middle, I	toba	cco	
and	be fill d off	Be								Stall			
7	2 should be and Mental is marked craumatic ev	2	Irving Go			19h Mailir	g Address (Street a						Zin Code)
Maryland	d 2 s th an th an traur			7/2501	15		Glen Ci				-		
	es 1 and 2 of Health I Item 27 I		Joseph Gott- bi 20a. Method of Disposition	other	20b. Plac	e of Dispo	sition (Name of	al -	Date	bare	20c. Loca	tion - City o	r Town, State
0 E	Pages nent of I int: If its iry or o		1 ☐ Burial 2 ☐ Premation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		State	copo.	litan Fı	" Dec ine ra l	lšer	2005 Vice	Alex	andr	rTown, State ia Virgini:
Baltimore,	permit. Pages Department of Important: If I eny injury or once.		21. Signature of Funeral Service Licer	nsee	,	22	. Name and Addres	s of Facility	Raus	ch Fu	nera	l Ho	me
-	5.5		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that c	caused the death.							<u> </u>	Approximate Interval Between
	Physician Physician		Immediate Cause (Final disease or condition	One cause on e									Onset and Death
	/Medical		resulting in death)	a Due to	Sepsis (or as a consequer	nce of):							3 days
- S	Examiner		Sequentially list conditions.	b	Aspiration	n Preu	mia						
	pe tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequer	ice of):							
_	cate be executed physician and the burial-transit	хап	that initiated events resulting in death) Last	c	Oral Phary	mpeal	dysphagia						
8760,	be e. sician buria	aiE				ĺ							
687	ficate physics physics ficate	edicai		d									
Box	death certific e attending p id for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnancy		10				230	I. Date of de	elivery
	death e atte	icia	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)		pirth 2 Fetal de nant at time of deat		Ectopic pregnancy Other (specify)					Month	Day Year
P.O.	at the de by the a tached	hys	9 Unknown					-					
	res that igned by be deta	þ	Part II. Dther significant conditions	contributing to de	eath but not resultir	ng in the ur	nderlying cause give	en in Part I.			-		to the cause of death?
ord	ław requires as been sign 2 should be	ted	Anemia							1 □ Ye	es 2/1		robably 4 Unknown
ec	e law has b	Completed	Congestive Heart F	ailure						24a. Was a autops	y	4b. Were a prior to death?	utopsy findings available completion of cause of
E	Th ate pag		Printer Mallitan							perform 1 Tes	No		s 2 No
Zi.	ysician: Th is certificate director, pag	Be	examiner?	Hospital:			Othe	25	•	heck only on			
Division of Vital Records,	Attending Physician: r death. sctor: After this certifici by the funeral director.	1: 70	1 ☐ Yes 2 ☑ No 27. Manner of Death			Outpation b. Time of	1 3LI DON	4 🗀 (4013)		5 Reside			ecify)
on	th. : Afte	tion	Natural 5 Pending 2 Accident investigatio		th, Day Year)	Injury	28c. Injun Worl M 1 □	<br Yes 2 □ No					
Visi	Attendil r death. ector: A by the fu	Certification:	3 Suicide 6 Could not b	e 28e. Place	of Injury - At home	e, farm, str	eet, factory, office		28f			lumber or F	Rural Route Number,
Ö	s after s after al Dire	Cert	4 [] Homicide	Dulida	ing, etc. (Specify)					City or Town	i, Siale)		
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	edicai	29a. Certifier (Check only one)	miner: On the b	best of my knowle asis of examination ner stated.								
	To the I within 2. To the I complet	ž	29b. Signature and title of certifier				29c. License			2		_	th, Dey, Year)
			Daniel (Mexin	nder		D5.	2815			12/29	/05	
	D		30. Name and address of person who										
	3				Lecnardto								
	Sta Registr	_	31. Date filed (Month, Day, Year)	4 2006)	legistra Signatur	K	Conte						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amenditem/3, per/IE, 2853,36/06 IT
State of Maryland / Department of Health and Mental Hygienen

1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7:48 Time of Death **Physician** GORDON BERNARD S. 2005 11:11 A ^M December 22 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) South **Funeral** South America Months 1⊠M 2□F Yrs. 484.92.6932 Director 56 Feb.18, 1949 Guyana, Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow traumatic event, the Mudical Examiner must be nutified at 1 Yes 2 No Director Takoma Park Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7807 Lockney Avenue, Apt #102 Iteme 23a Guyana, South America 20912-7437 death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after al Hygiene.

I Hygiene. "neturel", or ite 1 Never Married 25 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Education & Elementary/Secondary (0-12) College (1-4or 5+) School Teacher/Landscaper Art Work of Ground 5+ Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I int: If Item 27 is marked of Dover Doris Gordon 2 William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7437 19a. Informant's Name/Relationship (Type, Print) JoAnne R. Gordon/Wife 7807 Lockney Ave, Apt #102, Takoma Park, MD 20912-Depertment of Health Important: If Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington Cem 12/31/2005 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit. Depertr 21. Signature of Funeral Service Licenses eny le HINES-RINALDI FUNERAL HOME, INC. 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cadse (Final disease or condition resulting in death) **Physician** /Medical Due to for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? certificate 2 No 1 🗌 Yes Division of Vital 1 Yes 2 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes 2 No 1 Expatient 3 DOA 2 ER/Outpatient his 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Natural 5 Pending Injury after death.

Director: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide filled in Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier pletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 2005 30

State of Maryland / Department of Health and Mental Hygiefie Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) December 25 2005 William O. Graffen **Physician** 6:05 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Arcola Health & Rehabilitation Center Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country)
 New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1₩ 2□F 716 16 8753 93 01/16/1912 Director Usual Residence of Decedent death with the Merylend 10c. City, Town or Location 10a. State 10d. Inside City Limits Peges 1 end 2 should be filed within 72 hours after death with the Meryle ment of Health end Mental Hygiene.
ant: If Item 27 is marked other then "netural", or items 23a or 28a-4 show ury or other traumatic event, the Medical Exeminer ment be notified at 1 ☐ Yes 2 ☐ No Director Silver Spring Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9039 Sligo Creek Parkway #1116 20901 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ঐYes 2 ☐ No 17 Yes, Give Year or Dates: 1945 Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No altimore, Maryland 21215-0020 by Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specily only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Office Equipment 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Oramel Peck Graffen Lillian Gain 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9039 Sligo Creek Pkwy #1116/Silver Spg MD 20901 Lisa Graffen/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Depertment of I Important: If Ite any injury or of 12/27/ 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria VA 4 ☐ Donation 5 ☐ Other (Specify) 2005 22. Name and Address of Facility 21. Signature of Fun Advent Funeral & Cremation Services Annapolis and Falls Church Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final Pneumonia Days disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician end for use as the bunel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): signed by the and ld be deteched for 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Coronary Artery Disease δ 24b. Were autopsy findings available prior to completion of cause of death? s certificete has been sig director, page 2 should f 24a. Was an autopsy performed? Completed Atrial Fibrilation 1 ☐ Yes 2 ☐ No or Attending Physicien: efter death.

Director: After this certific 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No ၉ 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined To the Hospital or Atterwithin 24 hours efter des To the Funeral Director completely filled in by the 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🕅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D - 3233212/27/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh K. Gupta, MD 9801 Georgia Avenue, Suite 220, Silver Spring, MD

State Registrar

31. Date filed (Month, Day, Year) DEC 3 0 2005

strar's Signature 32. Re tion & sports

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05 = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2110 PM 125 ANNIE 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Shady Grove Adventist Rockville If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🔀 F 93 12/04/1912 577-03-1712 Wash., D.C. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
In: if item 27 is marked other then "natural; or items 23a or 28a-f show rry or other traumatic event, ire Modical Examiner must be notified at 10a. State 10b. County MD Montgomery Silver Spring 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 321 University Blvd. #324 20901 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 2 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Bailey Rebecca Lyles 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16312 Bawtry Court Bowie, Maryland 20715 Milton Gray/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Remg@al from State 1/03/06 Fort Lincoln Brentwood, Md 4 Donation 5 Other (Specify) 21. Signature of uneral Service Licens BHTT TO COUNTY OF THE PARTY OF 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sproximate proximate sproximate cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sproximate laboral Particular Courts (Courts Courts Immediate Cause (Final PNEUMONIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner METHICILLIN RESISTANT STAPH SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ng physician and as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď CHRONIC RENAL FAILURE 2 No 3 Probably 4 Unknown Completed BILATERAL PLEURAL EFFUSIONS 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 2 00 1 Yes certificate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 t To the Fu (Check only one) certifier 29c. License number 29b. Signature and title D 23177 PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CONGRESSIONAL MARIO BELLE DONNE 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 0 3 Registrar 2006

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month December 27, Physician Carolina Carmen Gomez 2005 3:20 ^p ^M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2K F 127-40-7589 Yrs. 89 June 25, 1916 Chile Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show J. Hygiene. . other than "natural", or Itema 23e or 200 .vent, the Medical Examiner must be indiffied at 1 ☐ Yes 2 No Maryland Montgomery Silver Spring Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20904 2501 Musgrove Road Chile death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Chilean Specify: White ۵ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygies
Important: If Item 27 is marked other tt
any injury or other traumatic event, the 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ernesto Gomez Unavailable 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jose Luis Montesinos/ Friend 607 Muriel Street, Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition December 31 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2005 Alexandria, Virginia 21. Signature of Foneral Service Licensee Francis Address Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication, that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Sepsis 14 Days /Medical Due to (or as a consequence of). Examiner 14 Days Pancreatitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Respiratory Failure 14 Days Due to (or as a consequence of): Box 68760. Physician/Medical Cholelethiasis IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Atrial Fibrillation, Cholecystitis Completed Deen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate has 1 Yes 2 No 1 Yes funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 K Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Hospital 29a. Certifie Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 019609 alman December 28, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raman Tuli, M.D. 10810 Darnestown Road, Suite 202, Gaithersburg, MD 20878 31. Date filed (Month, Day, Year) 32. egistrar's Signature State JAN 03 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Day Month **Physician** Ganelina December 29,2005 9:45 a^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Hebrew Home of Greater Washington Rockville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) DEC 20, 1922 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 🔯 F Belarus Director 469-19-3721 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural; or itams 23a or 28a-f show any injury or other treumatic event, the Medical Examinat must be notified at once. 10a. State 10b. County 1 ☐ Yes 2 No Director Rockville MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6121 Montrose Road, Smith Kogod 20852 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: white þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Accounting 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Zlata Igolnikova Zelenko Nochim ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 2447 St. Albert Terr, Brookeville, MD 20833 Dora S. Kantor/ Daughter 20b. Place of Disposition (Name of Judean Memorial Gardens Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/30/2005 Olney, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Thibadeau Mortuary Service, P.A. M00956 933 Gist Av., LL, Silver Spring, MD 20910 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Physician YEARS /Medical Due to (or as a consequence of) Examiner YEARS DIABETES MELLITUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-translt law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a I be detached fo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2X No 3 Probably 4 Unknown SENILE DEMENTIA page 2 should Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy perform 1 🗌 Yes 2X No the funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one. examiner Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred After t Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗍 Homicide

Division of Vital Records, P.O. Box 68760 Hospitel or Attending Physician: after death. filled in by 24 hours a completely within 2 To the the the ပ

Baltimore, Maryland 21215-0036

29b. Signature and little of certifier 29c. License number

and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

December 30, 2005

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

6121 Montrose Road, Rockville, MD 20852-4856 Barbara Kalazny, M.D.,

State Registrar 29a. Certifier

Medical

2008

			1- For Amend Item Registrar	25tate of Maryl 10c per FH	2851,000 Ce	18/06al rtificate	Health and of Death	Mental H	ygiene Reg. No	005	43612
	Dhoraini		1. Decedent's Name (First, Middle, La			1/		2. Date of E			3. Time of Death
	Physicia /Medic		TAUL K	ILHARD		HAK	Kins	1)8631	. /	31,20	
K	Examin	er	4a. Facility Name (If not institution, giv	e street and number)	1.1	4b. City, Town	n, or Location of Dea	th	4c.	. County of De	ath
			5. Social Security Number 6.5	1075 HOSP	Y.A. last birthday)	If Under 1 Ye	ar If Under 24 Hrs	8. Date of E	Righ	9.8	inhplace (State or Foreign
	Funeral Director			1 48 × 2□ F	Yrs.	Months Da			957	3.5	ryland
			Usual Residence of Decedent								
	nylan how		10a. State 10b. County		. City, Town or Lo		ltimore				10d. Inside City Limits
	80-f	cto	MD Baltim	ore 2	702 Kin g						1 ☐ Yes 2 ☐XNo
	vith th	Dire	10e. Street and Number	Dond		10f. Zip Cod				izen of What	Country?
	within 72 hours after death with the Maryland ene. Then "natural", or items 23a or 28e-f show he Madical Examiner must be notified at	Funeral Director	2702 Kings Ridge	12. Was Decedent Ever i	0116 12	2123	ol Hispanic Origin? (Speedy Voc or I	US		nerican Indian.
	ter de	ů.	11. Marital Status 11 Never Married 2 Married	Armed Forces?		Il Yes, specify C	Cuban, Mexican, Pue	to Rican, etc.)	10-	Black, Wi	
980	urs af	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give X Year or Dates:		1 □ Yes 2 X 0!	No Specify:			Specify: V	Mhite
21215-0036	72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation	16a. Dece	dent's Usual Oc	cupation ne during most of wo	orkina	16b. K	ind of Busines	ss/Industry
2	ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re	tired)	9			
2	led w lygier her th		12		Flor	al Desi	_	m - /Finsk Adida		etail F	lorist
and	be fi	Be	17. Father's Name (First, Middle, Last Edgar I. Hark				18. Mother's Na	et Mark		Surname)	
<u> </u>	hould d Mei mark matic	ဥ	19a. Informant's Name/Relationship		19b Maili	na Address (Str	eet and Number or F			or Town State	Zin Code)
Maryland	od 2 s lth an 27 le i		Margaret M. Harki			-	rd Road,		-		
ē	s 1 ar f Hea item		20a. Method of Disposition		b. Place of Dispo	osition (Name of matory or other	nlace)	Date	20c. L	ocation - City	or Town, State
Ë	Page lent o nt: if ry or		1 NBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		mory Cen		1/4	/2006	Stre	et, M)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department if Item 27 is marked other than "natural; or items 23a or 28e-f show mortant: if Item 27 is marked other than "natural; or items or other traumatic event, the Madical Examiner must be notified at Once.		21. Signature of Funeral Service Lice	nsee			dress of Facility	6M N	Sin Ol	Dolla	DA 17214
<u> </u>	89889		Helpy	1. Tovel	LUCK		eral Home,I			, leita	, PA 17514
П				polications that caused the cone eause on each line.	leath. Do not en	ter the mode of	dying, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Irrinediate Cause (Final disease or condition resulting in death)	a HodBking	Dise	ACE					14BAL
	/Medical Examiner		resulting in death)	Due to (br as a con	isequence of):						/
		-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a con	sequence of):						
ī	nsit	mln	cause. Enter Underlying Cause (Disease or injury		,						
Ċ,	exection and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a con	sequence of):						
8760,	cate be executed bhysicien and the burial-transit	dlcal		d							
9	ntifica ng ph	Wed	IF FEMALE:								
Вох	death certific e ettending p ad for use as	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I	Fetal death 3[⊒Ectopic pregna				23d. Date of o Month	delivery Day Year
	0 0	Physiclan/Me	1 Yes 2 No	4□Pregnant at time 9□Unknown	ol death 5[Other (specify)		-	100.101	buy roa
P.O.	The law requires that the de sie hes been signed by the e page 2 should be deteched f	Ph	Part II. Other significant conditions	contributing to death but not	resulting in the u	inderiving cause	given in Part I.	23e. Dio	d tobacco	use contribute	to the cause of death?
ds,	uires sign ld be	d by				, -		10	Yes 2	⊇ No 3□	Probably 4 Unknown
202	w requir been si should I	Completed						24a. W	as an	24b. Were	autopsy findings available
Re	: The law cete hes t , page 2 s	mo						20	topsy rformed?	prior t death	o completion of cause of
ta		Be C	25. Was case referred to medicat				26. Place of De	1 Yes			es 2 No
<u>></u>	Physicien: r this certific ral director,	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA	Other	Home 5□Re		6 ☐Other (S)	pecify)
0	ng Ph fter th ineral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o	f 28c. I	njury at Work?	28d. Describ	e how inju	ry occurred	
Sio	eath. or: A the fu	catle	2 ☐ Accident investigation	20		М .	1 ☐ Yes 2 ☐ No				
Division of Vital Records,	or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not 8 4 Homicide determined		At home, farm, st pecify)	reet, factory, offi	се	281. Location City or 7	(Street ar own, State	nd Number or 9)	Rural Route Number,
נ	To the Hospital or Attending Physicien: within 24 hours attendeath. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying P	hysician: To the best of my	knowledge deat	h occurred at th	e time, data and also	e and due to the	o cauco/s	and masses	a e etatod
-	• Hos 24 hr • Fun etely	Medical	(Check only 2 Medical Exa	miner: On the basis of exar and manner stated.	nination and/or in	vestigation, in n	ny opinion, death occ	curred at the time	e, date an	d place, and d	ue to the cause(s)
	To th within Fo the compl	Me	29b. Signature and title of certifier			29c. Lic	ense number		29d. Da	te signed (Mo	nth, Day, Year)
			(Xa, A)			DAG	11710		Dece	mber 3	1, 2005
	1		30. Name and address of person who	completed cause of death	(Item 23a) (Type						
	9			MO 600	N. WOIFE	Store	+ Balti	MORE, MI	12V/8	and Z	1287
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	0.			/		

DHMH 17 Rev 1/2001

			for State Registrar	State of Ma	aryland /		rtment of H tificate of I			giene Reg. Nő.	005	43613
	Physici	an	Decedent's Name (First, Middle, Last Della Finley Hes						2. Date of De Month Decemb		9, 2005	3. Time of Death 9:50 a M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or				County of Death	
	Funeral		Holy Cross Hospi 5. Social Security Number 6. S	x 7. Age	e (In yrs. last bi	irthday)	Silver S	If Under 24 Hrs	B. Date of Birt	th Year)	Montgom 9. Birthp	ace (State or Foreign
	Director		422-28-8372 1 Usual Residence of Decedent	□м 2∰ ғ	77	Yrs.	Months Days	Hours Min.	March 2	25, 1	928 AT	abama
	aryland ehow	_	10a. State 10b. County		10c. City, Tov						11	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the Mi	Director	Maryland Montgom 10e. Street and Number	ery	Silve	er Sp	oring 10f. Zip Code			10g. Citiz	en of What Coun	
	23s or		12818 Bushey Dri	ve			20906				USA	
980	n 72 hours efter death with the Maryland "natural", or Iteme 23a or 28a-f show salical Examilian mast be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			as Decedent of H Yes, specify Cuba □ Yes 2🏖 No		pecify Yes or No- to Rican, etc.)		4. Race - Americ Black, White, of Specify: Blac	etc.
15-0	n 72 ho "natur	leted	15. Decedent's Ec (Specify only highest gra	de completed)	168	a. Decede (Give ki life. Do	ent's Usual Occupi ind of work done of O NOT use retired	ation during most of wo	rking	16b. Kin	d of Business/Ind	lustry
212	filed within 7 Hygiane. sther than "n ent, the Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5 4	+)		nel Managen	ment Specia	alist			irs Office
Maryland 21215-0036	0 - 0 ×	To Be	17. Father's Name (First, Middle, Last) John L. Finley						ne (First, Middle, B. Harp		Sumame)	
lary	2 shoul and M ie mari	-	19a. Informant's Name/Relationship (Type, Print)			Address (Street			•		
	eges 1 and 2 should b nt of Health and Ments I: if item 27 ie marked / or other traumatic e		Donna P. Huie-Br 20a. Method of Disposition		20b. Place	of Disposi	Buford Station (Name of atory or other place	1 =	Date		Carolin cation - City or To	
Baltimore,	A 00		1 Burial 2 区 Cremation 3 日 4 Donation 5 Dother (Specify)		olitan	Crematory	2				Virginia
Ball	permit. F Departme Importar any injur		21. Signaturi of Funeral Service Licer	I Cole		F22	Name and Address INCIS Univers	Collins sity Blv	Funeral d, W, Si	Home lver	e Inc Spring,	MD 20901
			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	olications that caused one cause on each lin	the death. Do	not enter	r the mode of dyin	g, such as cardia	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Squamous Due to (or as a	Cell (inoma of	the Head	d & Neck			
ı	Examiner)£	Sequentially list conditions,	b. — Oue to for as t	a eurisuquenes	off:						
	cuted nd ransit	Examiner	day, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events	с.	·							
68760,	ificate be executed physician and ss the buriel-transit	edicai Ex	resulting in death) Last	Due to (or as a	a consequence	of):						
	- 00	/Medi	IF FEMALE:	23c. If yes, outcome	of pregnancy						2.1.0-1-1-1-1-1	
.O. Box	daatl e ette d for	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)			2.	3d. Date of deliver Month	ry Day Year
ords, P.	w requires that the been signed by the should be detache	Ď	Part II. Other significant conditions o	ontributing to death bu	ut not resulting	in the und	derlying cause give	en in Part I.		obacco us 'es 2 🗆	e contribute to the	e cause of death?
of Vital Records,	The law ete has b page 2 sl	Completed							24a. Was autop perfor	rmed?	24b. Were autop prior to con death? 1 \(\subseteq Yes	esy findings available apletion of cause of
Zit.	Physicien: T this certificet ral director, pa	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2□ER/O	utoatient	3□ DOA Othe	20	ath <i>(Check only o</i>		Other (Specify	}
ion of	ding h. After fune		27. Manner of Death 1 反 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day		Time of Injury	28c. Injury Work		28d. Describe h			<u> </u>
Division	5 E E 6	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	iry - At home, f c. (Specify)	arm, stree	et, factory, office		28f. Location (S City or Tow		Number or Rural	Route Number,
	Hospital 24 hours a Funeral I etely filled	edical		ysician: To the best of liner: On the basis of and manner sta	examination as							
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. License			29d. Date	signed (Month, L	Day, Year)
	5		Padmele tha	m·D	(lu :	<i>(</i> T 5		06003		12	129/	05
			30. Padad iden iden iden iden iden iden iden ide	completed cause of de 1500				Silver	Spring,	MD 20	0910	
	Sta Registr		31. Date filed (Month, Day, Year) NFC 3 0 26	32 Registra	r's Signature	Coal	the same					

United States 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 TYes 2 No If Yes, Give] 942-1946 Year or Dates: 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 █XNo Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Music Composer/ Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Katherine Clock Walter Spencer Huffman, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1602 Gridley Lane, Silver Spring, MD 20902 Priscilla Walker Huffman/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of December 28 20a. Method of Disposition George to Disposition (Name of place) Medical center versity 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 4 Donation 5 ☐ Other (Specify)

21. Signature Funeral Service Licensee

22. Name and Address of Facility Columbia Mortuary Services, P.O. box 58007 Washington, D.C. 20037

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Aspiration Pneumonia resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Ventral Hernia

Due to (or as a consequence of): Days Small Bowel Obstruction Due to (or as a consequence of):

Due to (or as a consequence of):

Months

resulting in death) Last

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 2 | Fetal death 4 Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

24a. Was an

1 Yes 2 No 3 Probably 4 Unknown

1,36 14

3. Time of Death

5:30 P. M

Birthplace (State or Foreign Country)

10d, Inside City Limits

Approximate Interval Between Onset and Death

Days

Year

1 ZYes 2 □ No

Kansas

25, 2005

4c. County of Death

10g. Citizen of What Country?

Montgomery

autopsy performed? 1 Yes 2 X No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medicat examiner? 1 Yes 2 No 27. Manner of Death 1 XNatural

2 Accident

4 - Homicide

3 Suicide

5 Pending investigation 6 Could not be determined

1 🔀 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No

Other 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Journa

Khoma

29c. License number D0058965

29d. Date signed (Month, Day, Year) December 27, 2005

30. Name and address of person who completed cause of death (Item) 23a) (Type, Print) 11119. Rockville, MD 20852 Saima Khawaja, M.D.

State Registrar 31. Date filed (Month, Day, Year) DEC 29 2005



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Baltimore, Maryland 21215-0036

Physician

Examiner

/Medical

the attending physicien and the the strangit that the strangit that the strangit that the strangit the strangit that the

should be detached

peeu

certificate

this

death.

To the Hospitel or At within 24 hours after of To the Funeral Direct

2

To the Funeral Director: After th completely filled in by the funeral

Records,

Vital

ō

WALTER

ģ

Completed

Be

Examine

Physician/Medical

þ

Completed

Be

2

Certification:

Medical

State of Maryland / Department of Health and Mental Hygiene

For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Vaar **Physician** James Palmer Haddow 11:30 am 2005 December 27, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery 3320 Chiswick Court, #2D | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 7, 1922 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 18 M 2□ F 83 Yrs. Pennsylvania 192-12-3972 Director Usual Residence of Decedent with the Maryland 10d. fnside City Limits 10c. City. Town or Location 10a. State 10b. County or 28a-1 show the Medical Examiner mant be notified at Silver Spring 1 TYes 2 No Maryland Montgomery Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code IISA 20906 238 #2D 3320 Chiswick Court, Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Bfack, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 🔀 No Specify: SpecifWhite 3 Nidowed 4 Divorced "natural", 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) at Hygiene. Atomic Energy Elementary/Secondary (0-12) Coflege (1-4or 5+) Government Security Detail Commission other traumatic svent, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fill timent of Health and Mental H tant: If Item 27 Is marked other. Georgina Cowan William Kerr Haddow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3208 Hitchcock Court, Olney, MD 20832 James Neal Haddow/ Son 20b. Place of Disposition (Name of 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State January 3, 20c. Location - City or Town, State Department of Important: If Its any injury or o Gate of Heaven Cemetery 2006 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Francis Address Corrins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 rellane Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Years Congestive Heart Failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Years Ischemic Cardiomyopathy Saturation list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physicien and s the burial-transit The law requires that the death certificate be executed Years Hypertension that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical use as the attending properties of IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. sate has been signed by the spage 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Chronic Renal Failure 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1 Yes Attending Physician: director. 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Certification; To 1 TYes 2 Tx No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death fniury Division 1 XNatural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ō To the Hospital within 24 hours a To the Funeral Completely filled 334 Certifier t 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place; and due to the causa(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D25947 December 28, 2005 20+1 use of death (Item 23a) (Type, Print) 30. Name and address of person who 3416 Olandwood Court, Suite 100, Olney, MD 20832 Evelyn Jackson, M.D. 31. Date fifed (Month, Day, Year) 3 Registrar's Signature State 2 9 2005 DEC Registrar

			1 - For Stata Registra MEND#18perFH1/6	State of Mar	yland / Dep	artme		ealth and	-		en o :	5	43616
н	Physici	ian		_					2. Date of I	D	ay	Year	3. Time of Death
	/Medi Examir		Isais 4a. Facility Name (If not institution, give	h Joseph I street and number)	HENIG	4b. Cin	. Town. or	Location of Dea	Decemb		c. County o		12:55 AM
	CABIIII		Holy Cross Hospita	-		_		Spring			Mont		ry
	Funeral Director		5. Social Security Number 6. Sec		In yrs. last birthday 90 Yrs.		er 1 Year	If Under 24 Hrs Hours Min	8. Date of E	Birth Day, Year 19	r)		lace (State or Foreign
Maryland	fed at	tor	10a. State 10b. County Maryland Montgon		Oc. City, Town or L	ocation er Sp	ring					10	0d. Inside City Limits
with the	a or 28a.	Direc	10e. Street and Number 1131 University Bl	Lvd., W. #5			ip Code	902			itizen of WI		
1215-0036 within 72 hours after death with the Maryland	jiene. r than "natural", or Items 23s or 28s-f ehow Its Medical Examinat must be notified at	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 X Midowed 4 Divorced	12. Was Decedent Ev. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:	er in U.S. 13.	Was Deci If Yes, sp		spanic Origin? (: n, Mexican, Pue Specify:	Specify Yes or I nto Rican, etc.)	No-	14. Race Black Specify:	, White,	etc.
21215-0036 od within 72 hours aft	giene. er than "natu . It's Medica	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Dece (Give life. Sa	dent's Usi kind of w DO NOT lesma	ual Occupa ork done d use retired) un	tion uring most of wo	orking		Kind of Bus		,
ב ב	Mental Hygi varked other vatic event, I	To Be (nak Henig				(un kno					2000
, Mar end 2 sh	ealth and n 27 Is m		19a. Informant's Name/Relationship (Ty Harold Henig, Son		1131	Univ	ersit	y Blvd.					Code) 20902 pring, MD
Baltimore,	Department of Health and Menta Important: If Item 27 Is marked eny Injury or other treumatic enge.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Disp cometery, cre Mt. Leba:			ì	Date 02/06		.ocation - C 1phi,		wn, State
Ball Permit	Depart Import eny In		21. Signatur Fraera Service Licenso	9					Funeral W, Wash			C 2	0012
/1	physicien and Medical subspiritions of the parial-transit	cal Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Jany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c Aspiratio Oue to (or as a c Altered M Due to (or as a c Parkinson	onsequence of): on Pneumon onsequence of): fental St. onsequence of):	nia atus	ae or aying	, such as cardia	correspiratory	arrest,			Approximate Interval Between Onset and Death
Geath certifica	igned by the attending phy be deteched for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 [4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	⊒Ectopic p □ Other (s					23d. Date Month		ry Day Year
7	been signed b should be dete	Ď	Part II. Other significant conditions con Chronic Obstructiv				cause giver	n in Part I.					e cause of death?
VITAL MECORDS, P.O. sicien: The law requires that the	CA CA	Completed	Psychosis Dehydration						per	s an opsy formed? 2 [X] No	pridea	ere autop or to com ath?] Yes 2	sy findings available apletion of cause of
cien:	ertific actor,	Be	25. Was case referred to medical examiner?						ath (Check only				
Attending Physician:	After this o	lon: To	27. Manner of Death 1 \(\overline{\Overline{\	ospital: 1 🔯 Inpatient 28a. Date of Injury (Month, Day Yo	2 ER/Outpatier 28b. Time of Injury	f	28c. Injury Work	at	fome 5 Res				
DIVISION al or Attending	within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, st Specify)	M reet, factor		es 2 No	28f. Location City or To	(Street ar own, State	nd Number e)	or Rural	Route Number,
To the Hoepital or	in 24 hour he Funera pletely fills	edicai	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of mer: On the basis of ex	amination and/or in	occurred vestigation	at the time	o, date and place nion, death occu	e, and due to the urred at the time	cause(s , date and) and mann d place, and	er as sta	ited. the cause(s)
		×	29b. Signature and title by gertifie			29	c. License 4786				te signed (i		
)			mpleted cause of death	ockledge	Driv		290, Be	thesda,	MD	2081	7	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 3 21	32. Régistrar's	Signature	parte	,						

State of Maryland / Department of Health and Mental Hygiene []

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** December 29, 2005 Virginia Healy 3:30 PM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Sacred Heart Home Hyattsville Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign
Country) **Funeral** Days Hours Months 1 □ M 2 T F Yrs. 578-28-7689 98 Washington, DC **Director** Feb. 22, 1907 Usuel Residence of Decedent the Marylenc 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 X Yes 2 ☐ No Funeral Director Md. Prince George's Hyattsville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 5805 Queens Chapel Road 20782 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 DNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done du life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home other 1 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) permit. Peges 1 and 2 should be fil.
Department of Health and Mental Hy
Important: If item 27 Ia marked oth
any Injury or other traumatic even Maurice Ager Charlotte McCann 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jane Barnes/Niece 5112 Remington Drive, Alexandria, Va. 22309 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Jan.7, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State New St. Mary's Cemetery 2006 4 ☐ Donation 5 ☐ Other (Specify) Bellmawr, New Jersey 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licenses 2222 Wisconsin Ave., NW., Washington, DC 20007 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Cardiopulmonary Failure Examiner Due to (or as a consequence of): Examiner Hypertension use as the bunal-transit or Attending Physician: The law raquiras that tha death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): physician and Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): datached for 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Dementia, Anemia, Osteoarthritis Completed by after deeth.

Obrector: After this cartificata has been signed in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? T Yas 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steted.

2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature end title of certifier D51520 January 2, 2006 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Bahram Pishdad, M.D., 1328 Southern Ave., SE., Suite 310, Washington, DC 20032 31. Dete tiled (Month, Day, Year) Registrar's Signature JAN 0 3 2006 Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygien@ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** December 29 Holland 2005 2:26 A M Thelma Irene /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Memorial Hospital Frederick 9. Birthplace (State or Foreign Country). 7. Age (In yrs. last birthday) 7 (Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, 5. Social Security Number 6. Sex **Funeral** 1 M 200 Months Days Hours 214-28-2413 Usual Residence of Decedent BURRITSVILLE Director with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State other then "natural", or items 23s or 28s-f show vent, the Wedical Examiner must be multiled at MEDERICK 1 Tes 2 No Director Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21703 SEAGULL CI 6691 Completed by Funeral Pagas 1 and 2 should be tiled within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: BLACK 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) House Scamstun alth and Mantal Hygir 27 is marked other r traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) FREDERICK HENDERSON ELSIE JONES 19a. Informant's Name/Relationship (Type, Print) OA Christian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LISA MARSHALL Ms. 21703 6691 SEAGULLET FRED item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Dapartmant of H importent: if ite eny injury or of once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State FRED. MD. ILEST HAVEN MEM. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GARY L. ROLLIN'S FURIERM NEAS 21. Signature of Funeral Service Licensee FRED. MS. 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Due to (or as a consequence of): infaction resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attanding physician and for usa as the burial-transit Hospital or Attending Physicien: The law raquiras that the death cartificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 20 No this cartificata 1 Yes : Attar this cartifical tunaral diractor, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☐ dio 2 ER/Outpatient 3 DOA 28c. Injury al Work? 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification; 1 Naturat 5 Pending within 24 hours attar death.
To the Funeral Director: Al 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO00572890 12/29/05 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 2-1716 Gessert 742 St groline 610 32. Registrar's Signature State 2006 Registrar

			For State Registrar	State of Maryla		ertificate of			Reg. No.	43619
	Dhysisi	20	1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	ath Day Ye	
	Physici /Medio		Barba	ra Ann	Hen	derson		Decembe		
	Examir	ner	4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death		4c. County of [
		М	Frederick Memor: 5. Social Security Number 6. Se	ial Hospital	rs. last birthda	Frede:		8 Date of Birti	Frede:	
	Funeral Director		213-40-4593	□ M 2/2 F / 1. Age ("")	64 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day	0,1941	Birthplace (State or Foreign Country)
	tand		Usual Residence of Decedent 10a. State 10b. County		City, Town or					10d. Inside City Limits
	Mary 	to	Md. Freder	rick F	reder	ick				1 Tes 2 No
	with the	Funeral Director	10e. Street and Number 4533 Mount	VILLE ROA	0	10f. Zip Code 217	01		10g. Citizen of Wha	t Country?
	death	era	11. Marital Status	12. Was Decedent Ever in		B. Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp	pecify Yes or No-	14. Race - /	American Indian,
5-0036	should be filed within 72 hours after death with the Maryland of Mental Hyglene marked other then "netural", or lieme 23e or 28e-f ehow imatic event, it a Madigal Examinat mata be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No		nican, etc.)		White, etc. Biack
2	72 ho	eted	15. Decedent's Ed (Specify only highest gra	fucation de completed)	16a. Dec	cedent's Usual Occup ve kind of work done . DO NOT use retire	oation during most of work	king	16b. Kind of Busin	•
2	ithin Ben	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire			private	families
2	Hygien Hygien Sther th	ပိ	17. Father's Name (First, Middle, Last)		C717	10 6416	,/		Maiden Surname)	
Maryland 2121	a la b ≥	To Be	Washington =	5. Weedon			Helen 1	Weedo	n	
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (1) Douglas E. Her	iders on (sor	1)453	iling Address (Street	ille Rd 1		ch Md.	21701
Baltimore,	00		20a. Method of Disposition 1	Removal from State	b. Place of Dis cemetery, co	position (Name of rematory or other pla	Cem Jan	Date 4, 2006	Frederi	
Baltir	permit. Page Department Important: if eny injury o		21. Signature of Funeral Service Licen		6	22. Name and Addre	of Facility	ineval	Home	
	40204	_	23a Part Fotor the disease or com	olications that caused the d	leath Do not e	10 WEST	Source S	or respiratory ar	TRICK MI	Approximate
	Physician /Medical		23a. Part1. Enter the disease or com- shock, or beart failure. List only Immediate Cause (Final disease or condition resulting in death)		Card	iac Arry				Interval Between Onset and Death
	Examiner			·	sequence oi).					
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Sua to (or as a con	sequence of):					
	cuted	Examiner	that initiated events	c.						
60,	ificate be executed g physicien and es the burial-transit	al Ex	resulting in death) Last	Due to (or as a con	sequence of):					
68760,	physicate t	edical		d						
.O. Box 6	ath cert ettendin for use	by Physician/Me	IF FEMALE: 23b. Was decedent pregrant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	etal death	B Ectopic pregnanc	у		23d. Date of Month	f delivery Day Year
٥.	w requires that the debeen signed by the should be detached	F	Part II. Other significant conditions of	ontributing to death but not	resulting in the	underlying cause gr	ven in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
ds,	signe d be	d b	5 1 6 15	10	10	7		1 🗆 Y	res 2 ☑ No 3 [Probably 4 Unknown
Ö	v requ been shoul	ete	Pales als 1	1.1. Du	- C			24a. Was	an 24h Wer	e autopsy findings available
Re	he lav	Completed	1019645+16	Zianey Dis	cale			autop	nsy prior deat	to completion of cause of th?
<u></u>	in: Ti ificete or, pa		25. Was case eferred to medical	~			26. Place of Dear			Yes 2 No
5	s cert direct	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 ER/Outpat	ient 3 DOA Ot	har		tence 6 Other	Specify)
ō	g Phy er thi		27. Mann of Death	28a. Date of Injury (Month, Day Yea		of 28c. Inju			now injury occurred	
Ö	ath r: Aft	atlo	1 ✓ atural 5 ☐ Pending 2 ☐ Accident investigation	n	, mijar		Yes 2 □No			
Division of Vital Records,	o or Atterder after de l' Directod in by the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, ecify)	street, factory, office		28f. Location (5 City or Tox		r Rural Route Number,
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Medicai C		ysician. To the best of my niner: On the basis of exan and manner stated.						
	To the within 2. To the Complete	Me	29b. Signature and title of certifier			29c. Licen:	se number		29d. Date signed (A	fonth, Day, Year)
)	, (179.	Lil MD		_ D00	47679	(December	31,2005
	4		30. Name and address of person who	(11 () 6.		1 14107	Foods	k hi	21703	
		ate	31. Date filed (Month, Day, Year)	32. Registar's S	ignature	t. H103,	1 venevi	- KC [, 2 (40)	
,	Regist		JAN 0 4	32. Register's S	w K	Snow!				
DH	MH 17 Rev 1/2	2001				The same of the sa	<u> </u>			

DHMH 17 Rev 1/2001

		1	For State Registrar	State of Marylan	-		nt of H		nd Me		giene Reg. No.	005	4362	0
			1. Decedent's Name (First, Middle, Las	it)					2	Date of De. Month	ath Day	/ Year	3. Time of Dea	
	Physicia		Douglas				Epo	00	0	Scamp	_	7 200	5 3:05	Рм
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City	, Town, or	Location of	Death		4c.	County of Deat	th	
	LAGIIIII	Ci	THE JOHN HOPKIN	IN HOSPITAL		301	Time	25	CIT	٠				
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday)	If Unde	r 1 Year	II Under 2	4 Hrs. 8	Date of Birt	h Year	9. Birt	hplace (State or Fo	reign
	Director		441-28-7007	X ^{M 2□ F} 74	Yrs.	Months	Days	Hours	Min.	Date of Bird (Month, Da 11y 19	, 19	31 Sout	h Caroli	na
-	0		Usual Residence of Decedent											
-	how		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation							10d. Inside City L	
2	Ma P-1	to	MD Montgom	ery Beth	esda								1 Tes 2	TMO
	2.28	i e	10e. Street and Number			10f. Zi	p Code				10g. Citi	izen of What Co	ountry?	
	72 hours aller beath with the Maryland natural', or iteme 23e or 28e-f ehow dical Examir er must be invittied at	Funeral Directo	4419 Chalfont Pla	ce		2	0816				US	A		
	E E	ner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Dece	dent of Hi	spanic Orig	in? (Specif	y Yes or No	-	 Race - Ame Black, Whit 		
٠	or it		1 Never Married 2 Married	1. Yes 2 No		1 ☐ Yes	2 X No	Specify:				Specify: 1.1h		
9500-612	rel',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:Korea	in							WII	ite	
ה ה	natu deal	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece (Give	kind of w	ork done a	lurina most	of working		16b. Ki	ind of Business	'industry	
7	E 9 9 9	ם	Elementary/Secondary (0-12)	College (1-4or 5+)			ise retired,				NT			
N	Hygiene. Hygiene. other then "	S		44	Regio	onal_	Direc		da Nama (i	First, Middle,		wsweek		
ב ב		Be	17. Father's Name (First, Middle, Last)					Alice			малоеп	Sumamei		
<u>X</u>	should be ind Mental marked c	ဥ	Douglas P. Jeppe											
Maryland	2 should be 2 should be 3 and Mental 1s marked c 1sumatic even		19a. Informant's Name/Relationship (•	,		or Rural F	Route Numbe	ər, City o	r Town, State, 2	Zip Code)	
	Health Health tem 27		Gabriele Jeppe	(Wife)			lfont	P1.		thesd				
e C	SE E E		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐		Place of Dispo emetery, cre	osition (Na matory or	ime of other place	e) Do	Dat cemb		20c. Lo	cation - City or	Town, State	
Ĕ	Pages nent of I nnt: if its		4 □ Donation 5 □ Other (Specify		ropol:	itan	Crema	atory	200	5 29,	Ale:	xandria	, Virgini	La
altimore,	permit. Pages 1 and 2 should Dapertiment of Health and Men Important: if Item 27 is marke eny Injury or other traumatic once.		21. Signature of Funeral Service Licer	500	2	2. Name a	nd Addres	s of Facility	omo					
n	A G E S G		Jun . ce	Lebot	$\sqrt{\frac{1}{2}}$	222	Visco	nsin .	ome Avenu	e NW	Was	hington	, DC	
		1	23a. Part. Enter the disease, or com- shock, or heart failure. List only	plications that caused the deat								0	Approximate Interval Betwee	ın
	hysician		Immediate Cause (Final	one cause on cause mo.	<u> </u>	1:							Onset and Dea	th
}	/Medical		disease or condition resulting in death)	Due to (or as a conseq	uence of):	1010	-						2 day 2	
	Examiner			diffuse 1	CAGR	B-0	11 1.	form.	namo				luma.	
		e	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):		1	7.17					1 1 2 2	
	cate be executed by sicien and the burial-transit	Examlner	cause. Enter Underlying Cause (Disease or injury that initiated events	0										
· ·	n an n an ial-tr	Exa	resulting in death) Last	Due to (or as a conseq	uence of):									
8760	ate be executed hysicien and the burial-transit	dical		d										
89	ificate p phys	edi												
Вох	eath certific ettending p	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		75	2017					23d. Date of de	livery	
m	d for	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2□Feta 4□Pregnant at time of d		⊒Ectopic ⊒ Other (s						Month	Day Yea	ſ
P.O.	the c	Physician/Med	9 Unknown	9□ Unknown										
<u> </u>	The law requires that the death certific tie has been signed by the ettending p page 2 should be detached for use as		Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	underlying	cause give	en in Part I.		23e. Did t	obacco ι	use contribute to	the cause of deat	h?
g	ures sign	d by								10,	Yes 2	ZNo 3□P	robably 4 ⊟Unki	nwor
ö	w requir been si should I	Completed								24a. Was	an	24b. Were a	utopsy findings ava	ilable
ě	has ne la	E								autop	osy imed?	prior to death?	completion of caus	e ol
<u></u>	icate									1 Yes	2 No	1 ☐ Yes	2 □ No	
=	icler certif recto	Be	25. Was case referred to medical examiner?	Hospital:			Othe	ar		Check only o				
ō	Physical distriction	J.	1 ☐ Yes 2 No 27. Manner of Death	1 La Inpatient 2	ER/Outpatie 28b. Time of		IUA	4 Li Nur		d. Describe		6 □Other (Spe	icity)	
5	After	o	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	м	28c. Injury Work	k?` Yes 2∐N			,	,		
Division of Vital Records,	Attending Physicien: r death. ector: After this certifice by the funeral director, I	Certification;	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b		ome larm st					Location (Street an	nd Number or R	ural Route Number	
<u>≥</u>	lor A Olrection by	it.	4 Homicide determined	building, etc. (Specif	(y)	ileot, racio	ry, onloo			City or To				
_	To the Hospital or Attending Physicien: The law within 24 burus eiter death. To the Funerei Director: Atten this certificate has gompletaly filled in by the funeral director, page 2		29a. Certifier The Certifying Ph	ysician: To the best of my kno	wledge des	th occurre	d at the tim	ne date and	I place an	d due to the	Cause/e	and manner a	s stated	
	Hos 24 ho Fun faly 1	edical	(Check only 2 Medical Exar	niner: On the basis of examina and manner stated.	ition and/or in	rvestigatio	n, in my of	pinion, deat	h occurred	at the time,	date and	d place, and due	e to the cause(s)	
	To the within 2 To the	Mec	29b. Signature and title of certifier	2.13.1107.310103.		2	9c. License	e number			29d. Da	te signed (Mont	th, Day, Year)	
	F 3 F 3		10000									4		
	5		genso		MO		DO	0617	11		Dece	mber	27,2005	
			30. Name and address of person who										2128	7
			31. Date filed (Month, Day, Year)	TO MD JOH 32. Registrar's Signa		KINS	HOUPIT	TAL 6	ce Nor-	th wolle	5+14	et 15.17n	mary LA	*>
	Sta Regist	ate	JAN 0 3	2nns	H 1	254 M.	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygietie | | 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Dec 28 2005 915 P Helena King /Medical 4c. County of Death 4b City Town or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Calvert Calvert County Nurising Center Prince FRederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 15 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🖫 F 026-20-3611 81 Yrs. Director Massachusettes Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Items 23s or 28e-1 show or other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Prince Frederick Director Maryland Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20678 United States Completed by Funeral 85 Hospital Road filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 Specify: white 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 □ Divorced "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Calvert Co. Public School 12 5+ Assitant Principal/school teacher permit. Pages 1 and 2 should be file. Department of Health and Mental Hyg Important: If item 27 is marked other eny injury or other treum.... 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jedlida Kratovill Jennie Robert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3162 Mallory Square Port Republic Maryland 20676 Marilyn Tarr- niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 31 2005 St. Paul's Episcopal Cemetery Prince Frederick Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home 04405 Broomes Is. Rd. Port Republic Maryland 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATRIAL FIBRILLATION Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown been signed by the s should be detached Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PARKINSON'S DISERSE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 or Attending Physicien: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗀 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation hours after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 | Homicide the Hospitel within 24 hours i filled TI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 40370 Kood, Trince Frederick, Mb 20678 who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

D

32. Registra Signature

2006

- 4

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Kerschbaum John Casper December 30, 2005 4:30 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Country Home, Ltd. Harwood Anne **Arundel** 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Oct 30, 19 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days 1**X** M 2□ F Months Hours 579-36-3248 78 Wash., Director 1927 D.C. Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or Items 23a or 28e-f show the Medical Examinet court be notified at 1 ☐ Yes 2 No Anne Arundel Harwood Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4187 Solomons Island Road 20776 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Completed by Year or Dates:1950-52 white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 owner of ironwork company ironworking other other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fill h and Mental H 7 is marked oti Be . Pages 1 and 2 should be iment of Health and Menta tant: if item 27 is marked Matthias Kerschbaum ٥ Leopoldine Kirchner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6355 Audubon Court, Dunkirk, MD L. Renee DeAtley, stepdaughter 20754 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or permit. Page Department of Important: if any injury or 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 01-06-2006 Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility llian + Tro Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumon 3 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner anem Seuere Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Menuc attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4 Pregnant at time of death 5 Other (specify) the 9 Unknown à been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown Be Completed 2 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 3 autopsy performed Rocled 1 Yes 2X No Physicien: Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 2 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 NOther (Specify) Assisted 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Living Hospital or Attending 1 X Natural 5 Pending death. 1 Yes 2 No 2 Accident investigation after death Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1140904 Maxey -mo January 3, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NANCY RIVERA-KING, MD. 10+1 1209 A MARDA LN., ANNAPOLIS, MD 2/403 31. Date filed (Month, Day, Year) 32. Register's Signature State 2006 > Elever.

Registrar

State of Maryland / Department of Health and Mental HygieRe[] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^{Day} 24, Month **Physician** 10:00P M December 2005 Francis A. Kirby /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rockville Montgomery 14007 Parkvale Road Months Days Hours Min. Feb. 23, 1920 6. Sex 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 85 019-18-8057 Massachusetts Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d, Inside City Limits 28e-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, it a Madical Examinar minal to notified a once. 1 Yes 2 No Director Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20853 USA 14007 Parkvale Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 KYes 2 □ No If Yes, Give Year or Dates: 1941-45 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Legitimate Box Office Manager Stage Theater 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lucy Holmes George Kirby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9622 Woodberry Street, Lanham, MD 20706 Jacquelynn A. Kirby/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Wother (Specify) Mausoleum Cate of Heaven Cemetery December 30 2005 Silver Spring, Maryland 21. Signature of Fugeral Service Licensee Francis J. Collins Funeral Home Inc Wil 500 University Blvd, W, Silver Spring, MD 20901 -6-17 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3 Years Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): the attending physicien Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probebly 4 ☑Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No 1 Yes 2 X No 1 Tyes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 51 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 ₩Naturat 5 Pending Injury after death. М 1 ☐ Yes 2 ☐ No investigation 2 Accident the the 6 Could not be determined 3 ☐ Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours aft To the Funerel Di 29a. Certifier Medicai 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D18219 December 27, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, MD 20850 Stephen Staal, M.D. 1396 Piccard Drive, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2005

3 0

			1 - For State of Maryland / Dep	partment of Health and Mertificate of Death		ene 05	3624
	Physicia		1. Decedent's Name <i>(First, Middl</i> e, <i>Last)</i> Philip Adam Krautwurst		2. Date of Death Month	^{Day} 28, 2005	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	December	4c. County of Death	9:20 p M
	Examin	er	National Lutheran Home	Rockville		Montgo	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,)		place (State or Foreign
	Director		577-03-9235	Months Days Hours Min.	June 16,	1910 Was	hington, DC
	darylan f show	ō	10a. State 10b. County 10c. City, Town or I				10d. Inside City Limits 1 ☐ Yes ※XXXIo
	or 28e-	Funeral Director	Maryland Montgomery Silver 10e. Street and Number 9710 Admiralty Drive	10f. Zip Code 20910	100	g. Citizen of What Cou USA	ntry?
	death v ms 23e	neral		. Was Decedent of Hispanic Origin? (Spo If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri	
036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other then "naturel; or items 23e or 28e-f show other traumatic event; the Medical Examinational be notified at	by	1 □ Never Married 2 □ Married 3 ☒ ※ Widowed 4 □ Divorced Armed Forces? 1 ☒ Yes 2 □ No If Yes 6 ive 1944-45	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	Rican, etc.)	Black, White, SpecifyWhit	
5-0	"natur	eted	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	ing 16	6b. Kind of Business/In	dustry
21215-0036	d withir giene. r then	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	onry Contractor		Construc	tion
Maryland	d be file entat Hyg ced othe c event,	To Be C	17. Father's Name (First, Middle, Last) Phillip Krautwurst		e (First, Middle, Ma ne Salome	aiden Sumame) a Breitwie	ser
ary	shout and Ma s mart	ř	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rura	al Route Number, (City or Town, State, Zip	Code)
-	1 and 2 Health sm 27 I		Linda K. Lawrence/ Daughter 1445 20a. Method of Disposition 20b. Place of Disp	3 Jaystone Drive,		pring, MD	
altimore,	ent of I		1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, cr	ematory or other place) Januar eaven Cemetery 2006	y 4,	,	ng, Marylan
Balti	permit. Pages 1 a Deportment of He Importent: If item any injury or oth		21. Signature Pineral Service Licensee	Transand Address of Tilins F 500 University Blvd	Tuneral H	ome Inc	
	Pnysician		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	nter the mode of dying, such as cardiac	or respiratory arres	La	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Dunc (or as a consequence of)	ascular d	Islas	Q .	wans
	ed sit	nlner	Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or injury				1
,	cate be executed obysician and the burial-transit	Examine	that initiated events resulting in death) Last				
68760,	ficate b physic s the b	edlcal	d				
.O. Box	at the death certific by the attending parached for use as for	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	ery Day Year
rds, P	es this	by	Part II. Other significant conditions contributing to dilativour not regulting in the	underlying cause given in Part I	23e. Did toba	cco use contribute to t	
Vital Records,	law las b	Completed	attacks.		24a. Was an autopsy	prior to co	opsy findings available impletion of cause of
a	Th ate pag	e Cor	25. W s cas by red to medical			ed? death? No 1 ☐ Yes	2 No
Z.	Physician: 1 this certifica al director, p	0 13	examiner, 1 Yes 2 100 Hospital: 1 Inpatient 2 EP/Outpati	Other	h <i>(Check only one)</i> me 5 □ Besiden	ce 6 □Other (Specia	6/1
ion of	ding After fune	atlon: T	27. Manner of Death 1 Fratural 5 Pending (Month, Day Year) 2 Accident investigation	of 28c. Injury at	28d. Describe how		7)
Division	in Little	ertification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	26f. Location (Stre City or Town,	et and Number or Rur State)	al Route Number,
	2 4 5 7	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de. 2 Medical Examiner: On the basis of examination and/or and manney stated.	tth occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cau red at the time, dat	ise(s) and manner as s e and place, and due t	tated. o the cause(s)
	To the Ho within 24 To the Fu	Me	29b. Signature and title of certifier	29c. License number	/\	d. Date signed (Month.	
•	271		trailer W. Keinston	D71/76	N	20ember	29, 2005
	J		30. Name and address of person who completed c. se of death (Item 23a) (Type Charles Karesh, M.D. 6033 Ridge Ro	Dad, Damascus, MD 2	20872		
	Sta Regist	6	31. Date filed (Month, Day, Year) JAN 0 3 2006 32. Figistrar's Signature	perti			

CPM 05-08778 Stephen Kelley

		For State Registrar 1. Decedent's Name (First, Middle, Las		aryland / Dep <i>Ce</i>	rtificate of			Reg. No.	JJ	4 3 6 2 5
Physicia Medic		Stephen Will	iam Kelley	7			Decembe	er 27,	Ž805	05:20 A
Examin	ner	4a. Facility Name (If not institution, give 18062 Stone Hollov	v Drive		Gaith	Location of Death ersburg		4c. Count	of Death	ery
uneral irector		213 11 0703	7. Age	a (In yrs. last birthday 20 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day July 1	, 1985	Coun	ace (State or Fore try) yland
how		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				1	Od. Inside City Lin
Ba-f s	Director	MD Montgom	ery	Gai	thersburg					1X Yes 2□
a or 2	Dir	10e. Street and Number 7221 Cypress Hi	11 Drive		10f. Zip Code	0879		10g. Citizen of United		1
Importation or result and western regiment of the properties of them 21 and white the most in the most in the most in the most in the most interest interest in the most interest interest in the most interest interest in the most interest in the most interest in	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No		pecify Yes or No- Rican, etc.)		ce - Americ	an Indian,
hen "naturel e Medical Ex	Completed t	15. Decedent's Ed (Specify only highest grant Elementary/Secondary (0-12)	ucation	+) (Giv	edent's Usual Occup a kind of work done DO NOT use retired	during most of work i)	king	16b. Kind of E		
of the care		17. Father's Name (First, Middle, Last)	2	Inst	aller/Stu	18. Mother's Nam	e (First Middle		catio	<u>n</u>
ked o	To Be	Henry W. Kelley					D'Angon		-,	
27 le mar r treumati	F	19a. Informant's Name/Relationship (7) Henry W. Kelley J			ing Address (Street			•		
nt: If Item ry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. Place of Disp cemetery, cre ParkLawn		Park Dec	Date	20c. Location	- City or To	wn, State
Importe eny Inju once.		21. Signature of Funeral Service Licen		2	emetery 22. Name and Addre eer Fark 1	ss of Facility D	eVol Fu	neral H	ome,	10 East
physicien and street transit transit	cai Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a	a consequence of): a consequence of): a consequence of):						
by the ettending sched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnanc) □ Other (specify) _	,			ate of delive	ry Day Year
gned be de	<u>ام</u>	Part II. Other significant conditions of	ontributing to death be	ut not resulting in the	underlying cause giv	en in Part I.		obacco use con res 2 No		e cause of death ably 4 □Unkn
certificate has been si irector, page 2 should I	e Completed	25. Was case referred to medical				GG Place of D	1 Yes	rmed? 2 \(\text{No} \)	Were autoprior to cordeath?	osy findings avail npletion of cause 2 No
within 2x rous entries. To the Funeral Director: After this certifies completely filled in by the funeral director; i	Certification: To B	examiner? 12C Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Inju. (Month, Day	Year) Injury 520 ury - At home, farm, s	of 28c, Injur Wor A M 1	4 Nuising n	ome 5 ☐ Residence 28d. Describe h	dence 6 Not now injury occu	her or Rura	not
Funeral E	Medical Ce	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best on the basis of and manner st	examination and/or i	th occurred at the tir	ne, date and place, pinion, death occur	and due to the	Caithe cause(s) and m	anner as st	mD ated.
To the	Mec	29b. Signature and title of certifier	and manner sta		29c. Licens	o.C.M.E.		29d. Date signe Decembe:		
		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type	, Print)	ceet, Bal				

			1 - For State Ragistrar	State of Marylai		artment of rtificate or		R	eg. No. 05		36 26
	Physici		1. Decedent's Name (First, Middle, Las Kenneth I. Kada					2. Date of Dea Month Decembe	m er 31,20	Year	: 05pm M
	/Medio Examin		4a. Facility Name (If not institution, give			4b. City, Town,			4c. County	of Death	.
	Francis		Suburban Hospit 5. Social Security Number 6. S		. last birthday)	Bethe		4 Hrs. 8. Date of Birth		omery 9. Birtholace	(State or Foreign
	Funeral Director			[™] 2□F 69	Yrs.	Months Day	s Hours	Min. (Month Day Aug 25	1936	Puerto	Rico
	show		10a. State 10b. County		ity, Town or Lo						nside City Limits
	the Ma 28a-1	ecto	MD Montgome 10e. Street and Number	ry l	Kensing	ton 10f. Zip Code			l 0g. Citizen of W		Yes 2 No
	h with	al Dir	3514 Raymoor Rd			2089			United	,	
036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f show amply injury or giver traumatic event, the Medical Examinar must be notified at ancie.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in I Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu		in? (Specify Yes or No- Puerto Rican, etc.)		- American Ir k, White, etc. White	ndian,
5-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occ kind of work don	e during most	of working	16b. Kind of Bu	siness/Industr	у
7121	iene.	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		DO NOT use retii			Auto C	are	
Baltimore, Maryland 21215-0036	uld be filed Jental Hyg rked other	To Be C	17. Father's Name (First, Middle, Last) Stanley Kadala					s Name (First, Middle, a Reyes	Maiden Sumame	θ)	
Man	12 sho		19a. Informant's Name/Relationship (or Rural Route Numbe	•	State, Zip Cod	(e)
ē.	Health Health Tom 2		Constance A. Kad 20a. Method of Disposition	20b.	Place of Dispo	sition (Name of		nsington,MI	20895 20c. Location - (City or Town,	State
<u>m</u>	Pages ant: Fi		1 🖾 Surial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		ate Of	natory or other p Heaven		-5-06	Silver	Spring	,MD
Balt	permit. Departr importe any inje		21. Signature of Funeral Service Licer	See		2. Name and Add		Joseph Gav Ave,N.W. Wa		•	
	Priysician /Medical Examiner	ıer	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, loading to immediate cause. Enter Underlying	plications that deused the dea one cause on each line. a. Acute Myoc Due to (or as a conse	ardial		_	ardiac or respiratory ari	est,	Inte	proximate grval Between set and Death ay
68760,	Physician: The law requires that the deeth certificate be executed this certificate has been signed by the ettending physicien and rail director, page 2 should be deteched for use as the burial-transit	edical Examiner	cause (Disease or injury Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conse	quence of):						-
.O. Box	that the deeth certific the by the ettending p deteched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnan Other (specify)	су		23d. Date Mon	of delivery oth Day	Year
۵.	res that igned b	by Pr	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	nderlying cause (given in Part I.	23e. Did to	bacco use contr	bute to the ca	use of death?
ord	w require been si should b	peted	Liver Failure,R	enal Failure,	Coagulo	pathy		1 U Y	es XONo	3 Probably	4 Unknown
al Records,	ding Physician: The law h. After this certificete has b funeral director, page 2 s	Completed						24a. Was a autop perfor	sy p med? d	Vere autopsy frior to complete eath?	indings available tion of cause of No
ξį.	sician certifi irector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: Inpatient 2[TERIO MENTE	- 20 pos 10	ther	of Death (Check only or			
) of	ig Phy ter this neral d	on: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	IL SU DOA	4 🗀 NUI:	sing Home 5 Resid	ow injury occurre		
sior	Attending r death. ector: After by the fune	catic	14 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	1		M 1	∏Yes 2 □N				
Division of Vital	rs after d ai Direct ed in by	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	reet, factory, offic	ө	28f. Location (S City or Tow	treet and Numbe n, State)	er or Rural Ro	ute Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai	29a. Certifier (Check only one) 1 Certifying Properties on the control of the certified Properties on the certifi	ysician: To the best of my kr niner: On the basis of examin and manner stated.	nowledge, deat nation and/or in	h occurred at the vestigation, in my	time, date and opinion, death	place, and due to the of occurred at the time, o	ause(s) and mar date and place, a	nner as stated and due to the	l. cause(s)
		×	29b. Signature and title of cerufier				nse number	2	9d. Date signed		
	8		30. Name and address of person who	- MD	am 23a) (Tyne		50117		January	10-20	06
			Eric J. Park, M.	D. 9901 Medic	al Cent	,	. Rock	ville,MD 20	0850		
	Sta	ite	31. Date filed (Month, Day, Year)	nns 32 legistrar's Sign	nature	arke	-				

Leplacement

Long, Rhoda

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** LEHMAN VIRGINIA 6:45A M PECKMBER 31, 2005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner CCHEN MONTGOM PR MONTGOMERY GENERAL HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea June 15, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Yrs 212-20-2131 82 1923 Virginia Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or iteme 23a or 28a-f ehow the Medical Examiner outst be notified at 1 Yes 2 No Director Maryland Howard Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1816 Long Corner Road 21771 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, . Pages 1 and 2 should be fil timent of Health and Mental H tant: if Item 27 is marked oth jury or other traumatic even William Edgar Baxter Nellie Cleveland Baxter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Ann Nordvedt/daughter 13720 Howard Road Dayton, Maryland 21036 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 1, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State crtant: if Chesapeake Crematory 2006 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit.
Departr
Imports
any njt 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner INTRA-ABDOMINA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner signed by the attending physicien and the detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Box 68760, Medical Certification: To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ALLMONTE 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 performed? Yes 2/11/10 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ctor: After this y the funeral c 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death To the Hospital or Atte within 24 hours after de To the Funaral Directo completely filled in by the 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homucide 1 C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 136252 DECOMBOR 31, 2005 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WHOTON MD 20902 STOVON T. KARIYA MI) 11501 GEDRGIA AVE #575 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 0 3 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiefiel 15 43629

		•	For State Registrar		.,, (tificate of		R	eg. No.	, .	40060
	Physicia	an	1. Decedent's Name (First, Middle,		T	. 7			Date of Dea Month	Day	Year	3. Time of Death
	/Medic		Joseph	Earl	Lang	утеу	11 On T		Decembe	1	2005	0020 ^M
	Examin	er	4a. Facility Name (If not institution,					or Location of Deat	h		y of Death	
100	700		Anne Arundel Me 5. Social Security Number		r e (In yrs. last b	irthday)	Annapo If Under 1 Year		. 8 Date of Birth		Arun 9 Birthr	
	Funeral Director		212-36-9273 Usuat Residence of Decedent	3738	66	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Feb. 3,	1939		place (State or Foreign htry) yland
	land w	ŀ	10a. State 10b. County		10c. City, Tox	wn or Lo	cation				1	10d. Inside City Limits
	Mary -f sh	ţō	MD Anne A	Arundel	Annap	oli	5					XXYes 2□No
	r 28a	Director	10e. Street and Number				10f. Zip Code			l0g. Citizen of	What Coul	ntry?
	th wit	a D	205 Hyde Park I)rive			21	403		USA		
	ems ems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. \	Was Decedent of I	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Ra	ce - Americk, White,	
215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. id other than "natural", or Items 23s or 28s-f show event, the Medical Examiner must be neitlised.	by	1 ☐ Never Married 2 ☐ Marrie 3 XX Vidowed 4 ☐ Divorced		1956–60	ł	l□Yes 2. XXNo		,	Speci		ite
ဂ ဂ	72 ho	sted	15. Decedent'	s Education	168	a. Deced	dent's Usual Occup	pation during most of wo	rkina	16b. Kind of E	Business/In	dustry
N	ithin Ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5		life. L	DO NOT use retire	d)	9			
7	led w lygier her th		10	acti	Tr	uck	Driver	19 Matharia Na	ma (Einst Middle	Truc		
Maryland	5 4 5 6	Be	17. Father's Name (First, Middle, L						me (First, Middle,		m <i>e)</i>	
Ž	should be fand Mental had Mental had marked of	스	Joseph E. Lang 19a. Informant's Name/Relationsh		10	h Mailin	n Address (Street	and Number or Ri	rite Dud		State Tir	Code
<u> </u>	id 2 s ith an 27 is i		Robert Langley					Lane, Ha				(0000)
ค์	es 1 and 2 should b of Haalth and Ment if item 27 is marked ir other traumatic e		20a. Method of Disposition				sition (Name of natory or other pla			20c. Location		own, State
<u> </u>	Pages ent of st: if i		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp				natory or other pia ematory		0-2005 B	altimo	ro M	D
Baitimore,	permit. Pages 1 Department of H Important: if ite any injury or ot		21. Signature of Funeral Service		Metro			ess of Facility Funeral		.A.	le, m	D
<u>-</u>	205 20	1	10-0.0	0			12 Ridge	ely Avenu	ie, Annap	olis, l	MD 21	401
	Physician		23a. Part1. Enter the disease, or o shock, or heart failure. List of firmediate Cause (Finat	only one cause on each lin	10.					est,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as	a consequence	of):	1111013	sepsi diseas				Jays
	Examiner		Sequentially list conditions	eun	stag	ce	renal	giseas	re			YEARS.
2	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	a consequence	of):						/
	ecute and trans	Examlner	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence							
8/60,	rtificate be executed ng physician and as the burial-transit			Due to (or as	a consequence	, OI).						
289	ficate p phys	edlc	(1)	d								
XOR		n/M	fF FEMALE: 23b. Was decedent pregnant	23c. ff yes, outcome			Je			23d. Da	ate of delive	əry
	The law requires that the death ce Itle has been signed by the attendi baga 2 should be datached for use	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 4□Pregnant at 9□ Unknown			Ectopic pregnand Other (specify) _	·y		М	onth	Day Year
1	that ned by data		Part II. Other significant condition	ns contributing to death be	ut not resulting	in the ur	nderlying cause gr	ven in Part f.	23e. Did to	bacco use con	tribute to the	ne cause of death?
Sp	quires n sign	d by	non quar	e my coci	and all	u	1 fan et)	01	1 🗆 Y	es 2□No	3 Prot	pabły 4 ∐Unknown
ecords,	s bee	lete	diabeties				/		24a. Was a	in 24b.	Were auto	psy findings available
Y	The lav	Completed							autop: perfor	med? 2 No	prior to co death? 1 \(\text{Yes} \)	mptetion of cause of 2□ No
Vita		BeC	25. Was case referr o medical					26. Place of De	ath (Check only or		103	20140
ot <	nysic nis ce direc	To E	examiner? 1 Yes 2 No	Hospital:	nt 2 ER/C	utpatien	t 3 DOA Ot	her: 4 🗌 Nursing H	dome 5 ☐ Resid	ence 6 □Ot	her (Specif	(v)
0	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year) 28b.	Time of Injury	28c. fnju Wo	ry at rk?	28d. Describe h	ow injury occu	rred	
<u>s</u>	tendi eath. tor: A the fu	catl	2 Accident investig 3 Suicide 6 Could n	ation				Yes 2□No				*
DIVISION	al or At s after d il Direct d in by	Certification;	4 Homicide determi	28e. Place of Inju- building, etc	ury - At home, to. (Specify)	farm, str	eet, factory, office		28f. Location (S City or Tow		ber or Rura	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of exeminer: On the basis of and manner sta	examination a	ge, death ind/or inv	n occurred at the ti vestigation, in my	ime, date and place opinion, death occi	e, and due to the curred at the time, o	ause(s) and m late and place,	anner as s and due to	tated. the cause(s)
	Fo the	Me	29b. Signature and title of certifier	, , 1			29c. Licen	se number	2	9d. Date sign	ed (Month,	Day, Year)
)	- > - 0		> Garrier	ine SI on	MO		D	57078	/	2/2	6/1	5
			30. Name and address of person v	pto completed cause of d	eath (Item 23a), (Type,	Print)			1	1.	
_			Ja equelene	eyan 200,	Med	ica		way,	tun ay	10/15/1	YD	21401
	Sta Registr		31. Date filed (Month, Day, Year)	2005 32. Segistra	ar's Signature	1	Cood :					

Jerryl Leach 05-8616 AKG

Type or Print in Bia	ick indelible	IIIK.	Ensure	All	Copies	Аге	Leg	IDIO
State of Maryland	/ Department	of H	ealth and	l M∈	ental Hv	giene	0.0	3 0

or i i i i i i i i i i i i i i i i i i i	an oopies Are Legiste.	
te of Maryland / Department of Health and	Mental Hygiene	13630
Certificate of Death	Reg. No.	-70000
	C Date of Doub	

		•	For State Registrar	State of Mary		tificate of			Reg. No.	CUL	43030
	Discovini.		1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physicia /Medic	_	Jerry Lee Leach					Decembe	er 20	, 2005	5:43 P M
	Examin	er	4a. Facility Name (If not institution, give				r Location of Deat	h	4c. Co	ounty of Death	
			Baltimore Washingto			Glen B				ne Arun	
	Funeral Director		214-62-0962	XM 2□F 7. Age (In)	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birt (Month, Day Jan 15)	, Year) 1953	9. Birthp Court Mary	lace (State or Foreign stry) yland
	and w	1	Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	cation				1	0d. Inside City Limits
	danyl feho	5	MD Anne Ar	undel	Odenton						1 ☐ Yes 2√∑No
	28e-	ect	10e. Street and Number	dilder		10f. Zip Code			10g. Citizer	n of What Cour	
	with Sa or		1234 St. Andrews	Lane		21113	\			USA	,.
	me 2	Funeral Director	11. Marital Status	12. Was Decedent Ever	in U.S. 13. \	Was Decedent of H		pecify Yes or No-	14.	Race - Americ	an Indian,
21215-0036	permit. Pages 1 end 2 should be tiled within 72 hours efter deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 le marked other then "natural", or Iteme 23a or 28e-f show any Injury or other traumatic event, If a Medical Exactinat must be notified at once.	Completed by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 (No lf Yes, Give Year or Dates:	i	fYes, specify Cuba	an, Mexican, Puer Specify:	o Rican, etc.)		Black, White, pecify: Wh:	
5-0	72 h	etec	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	lent's Usual Occup	during most of wo	rking	16b. Kind	of Business/Inc	dustry
21	ithin	훁	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	OO NOT use retire	d)			-	
2	ygier ygier t, t.		12		Plan	t Operato			Aspha		
Ē	tal H d oti	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle,	Maiden Su	mame)	
$\frac{1}{2}$	outd Mer harke	ဥ	Gary Lee Leach				Ruth Ha		-		
Maryland	l 2 sh l and l le m	Ì	19a. Informant's Name/Relationship (T)		1	g Address (Street					Code)
	end fealth m 27		Jeanette Leach (W			St. And		, Odento			
ō	ges to the rection or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, cren	sition (Name of natory or other place	1		20c. Locat	tion - City or To	wn, State
Ε̈́Ξ	tant:		4 Donation 5 Other (Specify)		Savage Co	-		4-2005	Savag	ge, Mary	/land
Baltimore,	permit Depar Impor any In pnce.		21. Signature of Funeral Service Licens	ee	22	. Name and Addre Hardesty	ss of Facility Funeral	Home, P	.A.		
	00 = e d		1,8 9. 0			12 Ridge	ely Avenu	e, Annap	olis,	MD 214	
-	-		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the c ne cause on each line.	leath. Do not ent	ar the mode of dyir	ng, such as cardia	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Atheroscla	notic (zandiova	scular	dise	ise		Oriset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con		·			-		
	LAdminici		Sequentially list conditions.	b							
	sit 9d	ine	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence of):						
	tificete be executed g physicien and as the burial-transit	Medical Examiner	that initiated events resulting in death) Last	Due to (or as a con	sequence of):						
60,	be ex	E		223 10 (3. 23 2 33.							
68760,	phys the	9		d							
	The law requires thet the death certificate be executed ete has been signed by the ettending physicien and page 2 should be deteched for use as the burial-transit		IF FEMALE:	23c. If yes, outcome of pre	agnancy			- 1	004	Data of dali-	_
Вох	eath cert ettendin for use	Physician/N	in the past 12 months?	1 ☐Live birth 2 ☐ I 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)	1		230	 Date of delive Month 	ry Day Year
o.	he d the ched	ysi	1 Yes 2 No 9 Unknown	9□ Unknown	or death 3	Cirial (specify) _					
P.0	thet the death hed by the etter deteched for u		Part II. Other significant conditions co	ntributing to death but not	resulting in the us	nderlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to th	e cause of death?
ds	signe d be	d by				, ,		1 🗆 Y	es 2 🗆 N	lo 3∏Prob	ably 4 Dunknown
Records,	w requir been si should	Completed									
36	hes hes	g I						24a. Was a autop perfor	sy	24b. Were autor prior to condeath?	osy findings available npletion of cause of
=	iclan: The l certificate he rector, page								21 X No	1 Yes	2□ No
Vital	Physician: this certificated director,	Be	25. Was case referred to medical examiner?	lospital:	\.	· all post Oth	000	th (Check only or			
ō	Phys this el di	٦.	1∑ Yes 2 No 27. Manner of Death	1 Inpatient	2 X ER/Outpatien	LOUDON	4 Iduising r	lome 5 Resid			")
E C	Sing After funer	5	1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	28c. Injur Wor	k?	28d. Describe h	ow injury o	ccurred	
S	death death stor:	cal	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - /	At home form the		Yes 2 □No	29f Leasting /F		(h	(D.). (I
Division	or A after Direction by	Certification:	4 Homicide determined	building, etc. (Sp	ecify)	вы, гастогу, опісе		28f. Location (S City or Tow		rumber or Hura	r Houle Number,
_	pital purs s erel filled		29a. Certifier 1 ☐ Certifying Phy	giging. To the best of my	leasuladas dasab		4.4. 4.4.1				
	To the Hospital or Attending Phys within 24 hours after death. To the Funerel Director: After this of completely filled in by the funerel director.	Medical		sician: To the best of my ner: On the basis of exam and manner stated.	nination and/or in	estigation, in my o	pinion, death occu	rred at the time, o	ause(s) and late and pla	d manner as st ace, and due to	ated. the cause(s)
	o the	₩.	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		29d. Date s	igned (Month, I	Day, Year)
	F 3 F 8		I him his,	miD		0.0	C.M.E.				
					(lton 20a) (Ton) • F1 • E •	1	ecelli)	er 21,	200)
			30. Name and address of person who co	ompleted cause of death (_{Print)} Penn Stre	eet, Ralt	imore M	arvla	nd 2120)1
	Sta		31. Date filed (Month, Day, Year)	32 Panistrar's S	ignature				y 10		
	Sta			OF AGE	DE A	and a					
	Registr	ar I	DEC 3 0 20		F						

State of Maryland / Department of Health and Mental Hygienen Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 9:30a M RUSSELL RICHARD LEE December 27,2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Sligo Creek Nursing Center Montgomery Takoma Park If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral X** 2 □ F Yrs Director 224-48-3955 Wash, D. C. 66 12-4-1939 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28e-f ahow the Medical Examiner must be notified at Seat Pleasant Yes 2 No Funeral Director P.G. 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 U.S.A. 708-65th Ave 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Federal Govt. Correction Offier 12th Pages 1 and 2 should be filed v iment of Heelth and Mental Hygie rant: if Item 27 is marked other t jury or other traumatic avant, III. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Enda White Milton Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 708-65th Ave Seat Pleasant, Md. 20743 Delores Lee-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of important: if any injury or once. Cheltenhem Vet.Cem 1-4-2006 Cheltenhem, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dunn & Sons 5635 Eads St, N.E. Approximate Interval Between Onset and Death enter the disease, or complications that caused the death, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physicien and s the burial-transit The law requires that the death certificate be executed Box 68760. Physician/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ŏ Month Day Year signed by the at d be detached for 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1. 12 certificete 1 Yes To the Hospitel or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifice completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death
Autural
2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUKESH (C. EHETAN, M.D. 76/ CARROLLAVE#260TAKUMA PARK, 7610, 31. Date filed (Month, Day, Year) 2. Registrar's Signature-State JAN 0 3 2006 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State o	f Marylar		artment of F		d Mental Hyg	giene	05	43632
			1. Decedent's Name (First, Middle,	Last)					2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physici /Medic		Ellis Lawrence	Lvon					Decembe		2005	4:50 P M
j	Examin		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City, Town, o	r Location of De			y of Death	
ı			Holy Cross Hosp				Silver		lee lee		tgome	
	Funeral		,	3.Sex 1 🙀 M 2 🗆 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		lin. (Month, Day	r, Year)	Cour	* *
	Director		216-12-4295 Usual Residence of Decedent		84				May 28	, 1921	Mary	land
	aryland ehow		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				1	Od. Inside City Limits
	Mar	ţ	Maryland Montg	omerv		Sí	lver Spri	nø				1 ☐ Yes 2 🙀 No
	th the	Director	10e. Street and Number	- C- C- F-			10f. Zip Code			10g. Citizen of	What Cour	ntry?
	be filed within 72 hours after deeth with the Maryland Hygiene. d other then "natural", or items 23e or 28e-f show do other then "asker" or items 23e or 28e-f show event, I're Medical Examinar must be notified at		304 Bonifant Ro	ad			20	905		USA		
	ep a	Funeral	11. Marital Status	12. Was Dec Armed Fo	edent Ever in U proes?	I.S. 13.	Was Decedent of Hi If Yes, specify Cubi	lispanic Origin? an, Mexican, Pu	(Specify Yes or No- ierto Rican, etc.)	14. Ra Bla	ce - Americ ick, White,	
20	s afte	by Fi	1 ☐ Never Married 2 ★ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 TYes If Yes, Gi	edent Ever in U prces? 2 No ve 1942 Pates: 194	_	1 ☐ Yes 2 🙀 No	Specify:		Speci	fy:	• •
3-003p	within 72 hours after ene. then "natural", or Ite re Medical Exeritive		15. Decedent's	Fducation	194	6 lea Dece	dent's Usual Occup	ation		16b. Kind of E	Wh	
င်	in 72	Completed	(Specify only highest	grade completed)		(Give	kind of work done DO NOT use retired	during most of v				<i>'</i>
7	with the state of	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Sett	lement Of	ficer		Title :	Insura Esta	ance
and	Hygi other	Bec	17. Father's Name (First, Middle, L.	ast)			IOMOIII OI		Name (First, Middle,			
<u>a</u>	uid be Menta Venta rrked	To B	Ernest Lvon					E11a	Carpe	nter		
Mary	es 1 end 2 should b of Health and Ment 1 Itam 27 le marked r other treumatice		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailin	ng Address (Street		Rural Route Numbe		, State, Zip	Code)
-	end 2 fealth m 27 m 27 her tre		Helen May Lyon		Wife		onifant B	oad Si	lver Spri			
o e	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	Removal from		cemetery, crei	sition (Name of matory or other plac	ce)	Date	20c. Location	- City or To	own, State
Ĕ	Pages ment of ant: If its ury or o		4 □Donation 5 □ Other (Sp.		Gat	e of H	Cemetery	Jan	3.2006	Silver	Spri	ng, Maryland
Saltimore	permit. Pages Department of I Important: If It eny Injury or o		21. Signature o Funeral Service L	consee),_		2. Name and Addre	ss of Facility	ns Funeral		- 10	
	70 E 9 9		Mohlew	700	٤		00 Univer	sity Bl	vd.,W.,Si	lver S	ring	MD 20901
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that	caused the deal each line.	th. Do not ent	er the mode of dyir	ng, such as card	diac or respiratory ari	rest,		Approximate Interval Between Onset and Death
)	Physician		Immediate Cause (Final disease or condition	a	Say	0515						Oriset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conse	uence of):						
		L.	Sequentially list conditions,	b	(or as a consec	tuonoo of):						
	ted Isit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	qualice oi).						
	al-trai	хаг	that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):					_	
9/9	death certificate be executed e attending physiclen and id for use as the burial-transit	dical E		d = =								
89	ificate g phy as the	ed		u.								
ŏ	anding use a	N	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn		75			23d. Da	ate of delive	эгу
n	death e atte	cla	in the past 12 months? 1 □ Yes 2 □ No	4□Preg	oirth 2 Feta nant at time of c		Ectopic pregnancy Other (specify) _	<u>′</u>		М	onth	Day Year
J Ö	it the by th tache	hys	9 🗆 Unknown	9∐ Unkr	own							
s S	requires that the death certific een signed by the attending p hould be detached for use as	by Physician/Me	Part II. Other significant condition	contributing to c	eath but not res	sulling in lhe u	nderlying cause giv	en in Part I.	23e. Did to	bacco use cor	Inbute to the	he cause of death?
2	w requir been si should I	ted	A UVUN CE	d 0/4/1	more	71 P	ONKIN	SOUS	_ 1 U Y	es 2 No	3 Prob	oably 4 Unknown
ပ္ပ	≥ .D .v	ple	VISENSE,	Inf Co	e0 1	acub	bitus.	Ulcar	24a. Was a autop	an 24b.	Were aulo	ppsy findings available mpletion of cause of
r	ysicien: The lav lis certificate has director, page 2	Completed			v				perfor	med? 2'QNo	death? 1 ☐ Yes	2 No
Vital Record	ertific ector.	Be (25. Was case referred to medical examiner?		,				Death (Check only or	ne)		
	5 5 5	ဥ	1 Yes 2 No	Hospital:	Inpatient 2			4 Nursing	g Home 5 Resid			(y)
Ĕ	ling F After Uner	ino in	27. Manuer of Death 1 Selatural 5 ☐ Pending	The second second	of Injury oth, Day Year)	28b. Time o Injury	Wor		28d. Describe h	ow injury occu	rred	
<u>s</u>	Attending Physicien: ir death. ector: After this certific by the funeral director.	icat	2 Accident investiga 3 Suicide 6 Could no	ot be 200 Bloo	of laine. At h	ema form et		Yes 2 □ No	29f Location /S	Stroot and Num	har or Dur	al Route Number,
DIVISION OF	i or Attending P effer death. Director: After t in by the funera	Certification;	4 Homicide determin	build	ing, etc. (Speci	hy)	eet, factory, office		City or Tow		Der Or Mura	ar Houle Number,
	spital ours neral filled	<u>S</u>	29a. Certifier 1 Certifying	Physician: To th	a best of my kn	owiedge, deat	h occurred at the tir	ne date and pla	ace, and due to the o	rause(s) and m	anner as s	tated
	E Ho	edical	(Check only E Medical E	xaminer: On the b	pasis of examination	ation and/or in	vestigation, in my o	pinion, death or	ccurred at the time, of	date and place	and due to	o the cause(s)
	To the Hospital or Attend within 24 hours efter death To the Funeral Director: completely filled in by the	₩	29b. Signature and title of certifier	<u> </u>	0 1		29c. Licens	e number		29d. Date sign	ed (Month,	Day, Year)
11			1000	Ivs.	37 6		Py	154.	7-1	12	12	7/05
l'	. 1		30. Name and address of person(w	no completed cau	se of death (Ite	m 23a) (Type,	Print)	1	1			
			yehey15	Neg	VYSIE	m.	0	H	DM Cr	035 7	405	270/
	Sta		31. Cate filed (Month, Day, Year)	32.1	egistrar's Sign	ature	rect)	//	U			
	Regist	rar	JAN	2000	A STATE OF THE PARTY OF THE PAR	No sty						

			For State Registrar	*	rtment of Health and N tificate of Death	Mental Hygie، Reg.	1113	43633		
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Alan C.	M. Lin			Day Year 28 2005	3. Time of Death 5:40p M		
	Examin Funeral	-	4a. Facility Name (If not institution, give street and Suburban Hospital 5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Bethesda If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) Coi	ery nplace (State or Foreign untry)		
	Director word and and and and and and and and and an	tor	114 30 0791 Usual Residence of Decedent 10a. State 10b. County	85 Yrs. 10c. City, Town or Loc		Feb. 7,	1920 C	hina 10d. Inside City Limits 1 □ Yes XXNo		
	h with the 23s or 28s	al Directo	Maryland Montgomery 10e. Street and Number 3005 South Leisure Wor		10f. Zip Code 20906	10g.	Citizen of What Co	untry?		
5-0036	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other then "natural", or itema 23e or 28e-f ehow imatic event, the Madical Exhibiter hall be notified at	d by Funerai	11. Maritaf Status 1 Never Married 2 Married 1 Yes	Decedent Ever in U.S. 13. V d Forces? If es 2 ☑ No	Vas Decedent of Hispanic Origin? (Si Yes, specify Cuban, Mexican, Puert ☐ Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify: AS i	e, etc.		
2121	led within 72 h ygiene. her then "natu it, the Madical	Completed	5+	ge (1-4or 5+) (Give)	ent's Usual Occupation kind of work done during most of wor IO NOT use retired) Architect	king	US Govern	·		
Maryland	should be fill of Mental H marked of matic even	To Be	17. Father's Name (First, Middle, Last) Jing Zhi Lin 19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	Yun Ye			lip Code)		
Baltimore, Ma	permit. Pages 1 and 2 should be Department of Heelth and Mental Important: If item 27 is marked only injury or other traumatic or once.		Nancy T. Lin / Wife 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal for 4 Donation 5 Other (Specify)	3005 20b. Place of Dispos	South Leisure Work sition (Name of natory or other place)	rld Blvd. Date 200		ring,MD20906		
Balti	permit. Departn Imports eny inju		21. Signature of Funeral S we Linensee	down 11	Name and Address of Facility Hi r 800 New Hampshir	e Ave Silv				
68760,	Physician /Medical Examiner physician and physician and physician and stipe principle.	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	on each line.	intestinal strow		or	Interval Between Onset and Death Zyears 8 years		
P.O. Box 6	I the death certing by the attending ached for use a	Physician/Me	in the past 12 months?		Ectopic pregnancy Other (specify)		TUMOT Typears			
	w requires that been signed to should be det	by	Part II. Other significant conditions contributing	to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobac				
Vital Records,	n: The law re ificate has be or, page 2 sh	e Completed	25. Was case referred to medical		00 Plant of Par	24a. Was an autopsy performed 1 Yes 2	prior to death?	topsy findings available completion of cause of		
Ö	To the Hospital or Attending Physicien: The i within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	To B	examiner? 1 Yes 2 No 27. Manner of Death 28a. C	1 Inpatient 2 ER/Outpatien Date of frijury Month, Day Year) 28b. Time of Injury	Othor	ath Check only one lome 5 Residence 28d. Describe how it		cify)		
Division	ital or Attend us after death ral Director: ,	Certification	4 Homicide	Place of Injury - At home, farm, stro puriding, etc. (Specify)		28f. Location (Stree City or Town, S	itate)			
)	To the Hospital of within 24 hours at Or To the Funeral D completely filled in	Medical	(Check only 2 Medical Examiner: On t	the basis of examination and/or invitation and/or invitation and/or invitation.	29c. License number DZ1531	erred at the time, date	o(t) and matter at and place, and due Date signed (Month Lec. 30	to the cause(s)		
	St Regist	ate rar	G. Peter Pushkas, M.I	11510 01d Ca	orgetown Road Ro	ckville, M	aryland	20852		

Lin, Alan 12/28/05 @ 530 pm

Certificate of Death

2. Date of Death

3. Time of Death

	1.	Dec
ysician		
Medical		

Funeral Director

with the Maryland or 28a-f show r than "natural", or Items 23a or 28a-f shov the Medical Examinar must be notified at death filed within 72 hours after other Pages 1 and 2 should be nent of Health and Mental int: If item 27 is marked o permit. Page Department o Important: If any injury or once. ā

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

attending physician and for use as the burial-transit The law requires that the death certificate be executed the been signed by t should be detach certificate has page 2 the funeral After or Attending death. after death Director:

Division of Vital Records, P.O. Box 68760

 30^{ay} Dec. 2005 Ruby Virginia Lewis 10 P 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Braddock Hgts. Frederick Vindabona Nursing Home 7. Age (In yrs. last birthday) 84 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 201) 9. Birthplace (State or Foreign 192:1^{Countr}Nd 6. Sex Months Days Hours 220-54-3585 1 ☐ M 2 🛱 F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ▼ No Frederick MD Middletown Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21769 5532 Carroll Boyer Rd. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Noticed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter M. Rice Myrtle Butts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Rice (Brother) 102 Prospect St., Middletown, MD 21769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 1 ☐ Buriai ∠ ☐ Other (Specify Smithsburg Crematory 1/3/06 Smithsburg, 21. Signature of Funeral Service Licens ²DonaTd^{dd}B^{of}FTHompson Funeral Home 31 E. Main St., Middletown, MD 21769 and Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or in failure. List only one cause on a chiline. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CELL CARCINOMA 20 yeur. Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi). Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ပို 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 22037 1/3/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

within 24 hours a To the Funeral D

600

rar's Signature

m D

32. Reg

2006

			For State of Mar Registrar	•	artment of Hertificate of L		lental Hygiei	THE STATE OF	43635	
Р	hysicia	an	1. Decedent's Name (First, Middle, Last)	.1 -			Date of Death Month	30, 2005	3. Time of Death	
	/Medic	al	Willie Dee Litt 4a. Facility Name (If not institution, give street and number)	те	4b. City, Town, or			30, 2005 4c. County of Death	10:45A M	
	xamin	er	Berlin Nursing Home		Berlin	Lood lorr or Dodin		Worceste		
Fu	ıneral		5. Social Security Number 6. Sex 7. Age (n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9 Birth	place (State or Foreign intry)	
Dir	rector		426-03-4777 1 N 2X F 85	Yrs.	World's Day's	Tiouis Will.	3/21/192	Ŏ O		
and	II II		Usual Residence of Decedent 10a. State 10b. County 1	Oc. City, Town or Lo	ocation				10d. Inside City Limits	
Mary	Maryland 10e. Street and Number 207 Old I 11. Marital Status		Maryland Worcester	Ocean	City				Yes 2 No	
h the	r 28a	irec			10f. Zip Code		10g.	Citizen of What Cou	intry?	
th Vil	23a c	aiD	207 Old Landing Road		2184	2		USA		
er dea	tems Term	nue	Armed Forces?	er in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White		
irs aft	l', or	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, 3 ☒ Widowed 4 □ Divorced 1 □ Yes 2 ☒ No If Yes, 2 ☒ No If Yes 3 ☒ No If Yes 2 ☒ No If Yes 2 ☒ No If Yes 2 ☒ No If Yes 2 ☒ No If Yes 2 ☒ No If Yes 2 ☒ No If Yes 2 ☒ No If Yes 2 ☒ No If Yes 2 ☒ No If Yes 2 ☒ No If Yes 2 ☒ No If Yes 2 ☒ No If Yes 2 ☒ No If Yes 2 ☒ No If Yes 3 ☒ No If Ye		1 ☐ Yes 2X No	Specify:		Specify: W	nite	
2 hot	ical E	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupa kind of work done d	tion	16b	. Kind of Business/li	ndustry	
ithin 7	- Wed	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired)	bring most or work	ng			
iled w	ther th		12 2 17. Father's Name (First, Middle, Last)	Secre	etary	19 Mothor's Name	(First, Middle, Maid	Oil Comp	any	
d be fental bental b	e e ve	o Be	Dee Richard Weaver				a Eva Bar	,		
shoul M	mari	F	19a. Informant's Name/Relationship (Type, Print)	19b. Mailii	ng Address (Street a				ip Code)	
and 2	n 27 is er tre		Carolyn Kennington/daughter	207	Old Landi	ng Rd., (Ocean City	, MD 2184	12	
of He	f iten		20a. Method of Disposition 1 □ xurial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, crei	matory or other place	9)		. Location - City or T	own, State	
mit, Pages partment of	iury o		*4 ☐ Donation 5 ☐ Other (Specify)		Memorial	1/5			ississippi	
permit Depar	eny in	<	21. Signature of Funeral Service Licensee	FSP 1	Holloway Bool Snow B	ineral H Hill Rd.,	ome Profe Salisbur	ssional A y, MD 218	ssociation 04	
			23a. Part1. Enter the disease, or complications that all sed the shock, or heart failure. List only one cause og each line.	e death. Do not ent	0		^	-	Approximate Interval Between	
	sician		Immediate Cause (Final disease or condition resulting in death)	seleratre	. <i>Lardio</i>	Vas cular	· Dise	ese	Onset and Death	
	edical miner		Due to (or as a c	consequence of):						
		er	Sequentially institutions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):						
cuted	ransit	Examiner	that initiated events							
,	cian a urial-1		resulting in death) Last Due to (or as a d	consequence of):						
cate be ex	physician and s the burial-transit	edicai	d							
D X C	nding use as		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of					23d. Date of delivery		
death	e atte	hysician/M	in the past 12 months?		□Ectopic pregnancy □ Other (s <i>pecify</i>)			Month	Day Year	
at the	by th	Phys	9 □ Unknown				-			
The law requires that the death certificate be executed	certificate has been signed by the attending rector, page 2 should be detached for use a	by	Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause give	n in Part I.	23e. Did tobaco	co use contribute to 2 No 3 Pro	4	
a w e	2 sho	Completed					24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of	
	ate his	Com					performed	? death?	2□ No	
Cien:	iis certific director,	Be (25. Was case referred to medical examiner?				(Check only one)	- 100-0000		
OI VIIA Physicien:	this cral dir	은	1 Yes 2 No Hospital: 1 Inpatient 27. Manner of Death 28a. Date of Injury	2 ER/Outpatier		ursing Ho	me 5 Residence		fy)	
ding C	: After	tion	1 Natural 5 Pending (Month, Day) 2 Accident investigation	'ear) Injury	Work	? Yes 2 □No	200. Describe now ii	nury occurred		
Attending or death.	ector by the	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury	- At home, farm, str	reet, factory, office		28f. Location (Street		al Route Number,	
itel or	led in	Cert	4 Homicide building, etc.	Specify)			City or Town, St	u.0/		
DIVISIO To the Hospitel or Attendi within 24 hours after death.	To the Funerel Director: After this completely filled in by the funeral dir	edical	29a. Certifier (Check only one) Certifying Physician: To the best of Medical Examiner: On the basis of e and manner state	kamination and/or in	h occurred at the tim vestigation, in my op	e, date and place, inion, death occurr	and due to the cause ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)	
To the	To til comp	M	29b. Signature and the of certific	~	29c. License	number	29d.	Date signed (Month)	Day, Year)	
	20)	1/1/ Wallet	- US	DDZ	18760	1	12/30	105	
	B,		30. Name and address of person who completed cause of dea	th (Item 23a) (Type,	Print)	Garti	41	Fruk		
	Sta	ote	31. Date filed (Month, Day, Year) 32. Mistrar	s Signature	10201	047141	your !	awier 4	109 UL	
	Regist		JAN 0 3 2006	J # 1	back !		٧ /		17677	

Little, Willie

State of Maryland / Department of Health and Mental Hygierie | - State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death DEC. **Physician** 29 2005 SUZANNE MARIE MONARD 2:00 P M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ADVENTIST HOSPITAL MONTGOMERY SHADY GROVE ROCKVILLE If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Months Davs Hours Min 049-34-3406 Director JAN 14 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Experience must be notified at MONTGOMERY POOLESVILLE MD 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20837 USA 17611 KOHLHOSS ROAD death Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 should be filed within 72 hours after a n and Mental Hygiene. 'Is marked other then "naturel", or Its 1 Never Married 2 Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify: Specify: WHITE Completed by If Yes, Give-Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRODUCTION LINE VIDEO LABS 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARTHA CABLE THOMAS LAWLOR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a. Important: If Item 27 le any injury or other trau 17611 KOHLHOSS ROAD, POOLESVILLE, MD 20837 JAMES MONARD / SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) FREDERICK CREMATORY 1/2/06 FREDERICK, MD 22. Name and Address of Facility HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, MD 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PNEUMONIA 3 davs disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner **EMPHYSEMA** 10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner anding physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of). P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ LUNG CANCER 1 Yes 3 ☐ Probably 4 ☐Unknown 2 No been sign Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy 1 🗌 Yes 3/2 No Hospitel or Attending Physicien: after death.

Director: After this certific.
I in by the funeral director, Be 25. Was case referred to medical 26. Place of Death | Check on y one examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ٩ 1 Yes 2 No Inpatient (Month, Day Year) 28b. Time of Injury Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours af ie Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. To the I To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifies D46187 DEC 29, 2005 IL OR NILLSIMA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKVILLE, MD 20852 11125 ROCKVILLE PIKE, #208, KURUVILLA 32. Regist s Signature State Been 2006 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** EUGENE DECEMBER 31, 2005 7:25 P.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner - Chevy ChasE MONTGOMERY CARE HENY CHASE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Oct 19, 1927 Birthplace (State or Foreign Country) _cFuneral 1 M 2□ F Yrs. Director 78 Oklahoma Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 Is marked other than "netural", or items 23a or 28a-f show traumatic event, the Modical Examinator must be notified at 1 ☐ Yes 2 No Directo Silver Spring Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20901 USA by Funeral 10802 Lockridge Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 🔀 Married 1 XYes 2 No If Yes, Give 1946-47 Year or Dates: 3altimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 ☐XNo Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Engineer Federal Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked othe any linury or other traumatic event, 9008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Berlin Martin Ernestine Ellis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michele L. Frome/Wife 10802 Lockridge Drive Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jan 2, 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2006 Chesapeake Crematory Beltsville, Maryland 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Dementio Examiner Due to (or as a consequence of) Examiner signed by the attending physician and d be detached for use as the bunal-transit death certificate be executed Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Box 68760, Physiclan/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Chronic Obstructive pelmanory Division of Vital Records, Ş Q 24b. Were autopsy findings available prior to completion of cause of death? certificate has been si irector, page 2 should I Completed 24a. Was an autopsy performed? 1 🗆 Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? å 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No After this 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death the To the Hospital or Atter within 24 hours after de: To the Funeral Director completely filled in by th 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 00054566 JANUARY 1, 2006 41)02 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1220 A East Jup pa Road, Sich 250, Toluson, MD21286 Sunitha Bhogavilli 32. Redistrar's Signature 31. Date filed (Month, Day, Year) JAN 0 3 2006 Registrar

		1	For State Registrar	State of Marylar	Cei	tificate of	Death		Reg. No.	700	43530		
35 B		_	1. Decedent's Name (First, Middle, Last)					2. Date of Do Month	eath Day	Year	3. Time of Deat		
Phys	edica		NATHAN MORRIS					DECEMBE	R 29,	2005	8:15 A		
Exan			4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o	r Location of Death	1	4c.	County of Death	n		
			ANNE ARUNDEL MEDICAL C	ENTER		ANNAPOLIS			ANN	E ARUNDEL			
Funer	ral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	9. Birth	nplace (State or Fore		
Directo	-		214-03-8992	M 2□F 98	Yrs.	Months Days	Hours Min.	JULY 19	1907	MARYL	AND		
			Usual Residence of Decedent			, , , , , , , , , , , , , , , , , , , ,							
land ow		ſ	10a. State 10b. County	10c. Ci	ty, Town or Lo	cation					10d. Inside City Lin		
Mary		ŏ	MARYLAND QUEEN ANNES	CTEV	ENSVILLE	,					1 ☐ Yes 2 🖔		
the 1		Director	10e. Street and Number	DIEV	THO A THIE	10f. Zip Code		10g. Citizen of What Country?					
with a sor	i												
ath v		2	414 KENTMORR ROAD			21666				U.S.A.			
within 72 hours after death with the Maryland ene. than "neturel", or Iteme 23a or 28a-f ehow the Modical Extending from the notified at		Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. \	Was Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or N o Rican, etc.)	0-	 Race - Amer Black, White 			
afte or It	1	ਜ਼	1 Never Married 2 Married	1 ☐ Yes 2 🖔 No If Yes, Give		1 □ Yes 2 No	Specify:		j	Specify:			
ours.		ğ	3 X Widowed 4 Divorced	Year or Dates:						WI	HITE		
n 72 hours "neture!",		Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Deced	dent's Usual Occup kind of work done	ation	kina	16b. Ki	nd of Business/l	ndustry		
nin 7		퓚	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)	, ung					
giene giene rthe		E	10		BUSINE	SSMAN			REA	L ESTATE			
be filed within tal Hygiene. d other than	•		17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle	, Maiden	Sumame)			
		Be	ADDAHAM	ODDIC			Permen		DETM	COLD			
d 2 should be file th and Mental Hy t7 is marked oth traumetic event		၉		ORRIS	10b Marilia	ng Address (Street	ESTHER	eal Courte Alvert	FEIN		in Cadal		
2 st and ls n			19a. Informant's Name/Relationship (Ty	pe, Printj	190. Maili	ng Address (Street	and Number of At	irai noute ivuini	our, only of	1 10WII, 31816, 2	(p C008)		
	8 11	11.	MARK LERNER/GRANDSON			HUFF COURT	, N. BETHES	- A					
of H	A .		20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ R	i	Place of Dispo cemetery, crer	sition (Name of matory or other place	ce)	Date	20c. Lo	cation - City or	Town, State		
Pages nent of snt: If it	b		4 □Donation 5 □ Other (Specify)		DEN OF R	EMEMBRANCE	01/01	./2006	CLARK	SBURG, MA	RYLAND		
permit. Pages 1 at Department of Hea Important: If item eny injury or othe	Υ.	1	21. Signature of Funeral Service License		22	2. Name and Addre	ss of Facility			,			
Dep	g		Munuda	Sudaura	HI	NES-RINALD	I FUNERAL H	HOME, INC.					
		-	Manua	Dualeway	- 11	800 NEW HAI	MPSHIRE AVE	NUE, SIL	ZER SP	RING, MAR	YLAND 20904 Approximate		
	-		23a. Part1. Enter the disease, or complete shock, or heart failure. List only or	e cause on each line.	an. Do not ent	er the mode or dyn	ig, sucii as cardia	or respiratory	arrost,		Interval Between Onset and Death		
Physicia	an		Immediate Cause (Final disease or condition		-	Tule Da							
/Medic	al	resulting in death) Due to (or as a consequence of):) = (
Examin	er		ACUTE RENAL FAILURE								Wo Da		
	£	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse									
ted nsit		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	UROSEL	2125					+	Tille Oc		
and and I-tra		xar	that initiated events resulting in death) Last	c. Due to (or as a consequence of):							000 34		
icate be executed physicien and s the burial-transit	!	<u>=</u>											
icate t physics the b		edical		·									
			IF FEMALE:										
death certif e attending od for use a		ician/M	23b. Was decedent pregnant	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnanc	v		1 4	23d. Date of deli			
deat a att		2	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at time of		Other (specify)	, 			Month	Day Year		
at the de by the a tached t		Physi	9 Unknown	9∐ Unknown				27/223	حلت				
law requires that the as been signed by the 2 should be detache		<u>=</u>	Part II. Other significant conditions cor	ntributing to death but not re	sulting in the u	nderlying cause giv	ren in Part I.	23e. Did	tobacco u	ise contribute to	the cause of death?		
ires sign d be		ģ						10	Yes 2	3 □ Pr	obably 4 🗀 Unkno		
w require been sig should b		Completed											
e law has b		흥						24a. Wa auto	s an opsy	24b. Were au	topsy findings availa completion of cause		
The tree had bage	20 20 20 20 20 20 20 20 20 20 20 20 20 2	6							ormed?	death?	2□ No		
		ပ	25. Was case referred to medical		5 - 1 - 1 - 1		26. Place of De						
		co	examiner?	lospital: 1 Inpatient 2	1 ED 10	Ott	nor-						
sicle cert rect		ဠ	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time o			28d. Describe		6 □Other (Spec	city)		
Physician: The this certificate his aldirector, page				(Month, Day Year)	Injury	Wo		200. 00301100	now injui	y occurred			
ing Physicia Mer this cert meral direct		<u>e</u>	1 Natural 5 ☐ Pending		M 1	Yes 2 □ No							
ding Ph h. After th funeral		ation	2 Accident investigation		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Str								
Attending Ph or death. rector: After th by the funeral		tification;	2 Accident investigation			reet, factory, office					ral Route Number,		
Attending Ph ar death. ector: After th by the funeral		Sertification;	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h building, etc. (Spec		reet, factory, office			(Street an own, State		ral Route Number,		
Attending Ph ar death. ector: After th by the funeral		ai Certification;	2 Accident 3 Suicide 4 Homicide investigation 6 Could not be determined	building, etc. (Spec	ify) owladgs, deat	h Jecumud at this ti	ina, date and place	City or To	own, State) Fand wanner as	stated.		
Hospital or Attending Ph 4 hours after death. Funeral Director: After th ely filled in by the funeral			2 Accident 3 Suicide 4 Homicide investigation 6 Could not be determined	building, etc. (Spec	ify) owladgs, deat	h Jecumud at this ti	nia, date and place pinion, death occi	City or To	own, State) Fand wanner as	stated.		
Hospital or Attending Ph 4 hours after death. Funeral Director: After th ely filled in by the funeral		Medical Certification;	2 Accident 3 Suicide 4 Homicide 23 Certifier (Check only) 2 Medical Exami	building, etc. (Spec	ify) owladgs, deat	h Jecumud at this ti	ppinion, death occu	City or To	own, State) Fand wanner as	stated: to the cause(s)		
or Attending Phitter death. Director: After thin by the funeral		edicai	2 Accident 3 Suicide 4 Homicide 2 Centre (Check only one) 2 Medical Exami	building, etc. (Special of the bast of my known of the basis of examination of the basis of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of t	ify) owladgs, deat	h occursu at the trivestigation, in my o	opinion, death occu	City or To	eques(s), date and	and manner as I place, and due te signed (Monti	clated: to the cause(s) h, Day, Year)		
Hospital or Attending Ph 4 hours after death. Funeral Director: After th ely filled in by the funeral		edicai	2 Accident 3 Suicide 4 Homicide 2 Centre (Check only one) 2 Medical Exami	building, etc. (Special of the bast of my known of the basis of examination of the basis of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of t	ify) owladgs, deat	h occursu at the trivestigation, in my o	ppinion, death occu	City or To	eques(s), date and	and manner as I place, and due te signed (Monti	clated: to the cause(s) h, Day, Year)		
Hospital or Attending Ph 4 hours after death. Funeral Director: After th ely filled in by the funeral		edicai	2 Accident 3 Suicide 4 Homicide 2 Centre (Check only one) 2 Medical Exami	building, etc. (Spec elcian: To the best of my kn ner: On the basis of examin and manner stated. ompleted cause of death (Ite	owlodgs, deat ation and/or in im 23a) (Type,	h occurred at the tovestigation, in my of 29c. Licens	se number	City or To	eques(s), date and	and manner as I place, and due te signed (Monti	clated: to the cause(s) h, Day, Year)		
Hospital or Attending Ph 4 hours after death. Funeral Director: After th ely filled in by the funeral		edicai	2 Accident 3 Suicide 4 Homicide 2 Certifier (Check only one) 2 Medical Exami 290 Signature and title of certifier 30. Name and address of person who contains the contains and contains the contains	building, etc. (Spec elcian: To the best of my kn ner: On the basis of examin and manner stated. ompleted cause of death (Ite	owledge, ceat ation and/or in m 23a) (Type,	h occurred at the to vestigation, in my of 29c. Licens	se number	City or To	eques(s), date and	and manner as I place, and due te signed (Monti	stated: to the cause(s)		

			1 - For State Registrar	State of Maryla		artment of F			giene	43639
			1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea		3. Time of Death
	Physici /Medio		Mary Beth	Massey				Decembe	r 22,200)5 10:20 A ^M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Dea	ath	4c. County of	
			Hebrew Home			Rockvill	e		Montgon	2
	Funeral Director		5. Social Security Number 6. Social Security Number 1	9x 7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		y, Year)	Birthplace (State or Foreign Country) Oklahoma
	pu s		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	ocation				10d. Inside City Limits
	show	5				oution.				1 ☐ Yes 2 ☐ No
	28a-f	Director	Virginia Fairfax 10e. Street and Number		McLean	10f. Zip Code			10g. Citizen of W	
	with a or	급	1115 Brentfield Dr			22101				nat Country?
	eath	era	11. Marital Status	12. Was Decedent Ever in	n IJ.S. 13		ispanic Origin? (USA 14 Bace	- American Indian.
36	be filed within 72 hours after death with the Maryland stal Hygiene. Id other than "natural", or itams 23a or 28a-f show adout, the Medical Examinational be notified at	by Funeral	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	an, Mexican, Pue Specify:	erto Rican, etc.)		white, etc. White
Maryland 21215-0036	2 hou	ted	15. Decedent's Ed	ucation		dent's Usual Occup			16b. Kind of Bus	siness/Industry
75	n 77	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of wi d)	orking		•
212	d with	E O	12	College (1-401 5+)	Homema	aker			Own Home	2
פ	m 0 W	Be C	17. Father's Name (First, Middle, Last)	-			18. Mother's Na	ame (First, Middle,	Maiden Sumame	9)
<u>la</u>	12 should be filed within h and Mental Hygiene. 7 Is marked other then "treumatic avent, the Me.	ToE	Louis Massey				Irene	Greenshau	1	
ary	short and N		19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Street	and Number or F	Rural Route Numbe	er, City or Town, S	State, Zip Code)
	and 2 salth n 27 l		Mark S. Massey/S	on	1.115	Brentfie	ld Drive	. McLean	. Va. 22	2101
J.	itam oth		20a. Method of Disposition	20	 b. Place of Dispo 	osition (Name of matory or other place		Date	20c. Location - 0	City or Town, State
Ē	nit. Pages partment of loorant: If its injury or of injur		1 ☐ Burial 2 🌠 Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specify	Removal from State) M				2/27/05	Alexandr	ia, Virginia
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic as once.		21. Signature of Funeral Service Licen	see	2:	2. Name and Addre Money & K	ss of Facility ing Fune	eral Home	, Inc.	
	¥		23a. Part1. Enter the disease, or comp	olications that caused the d	eath. Do not en	171 W. Mar ter the mode of dyin	ple Ave. g. such as cardia	, Vienna ac or respiratory ar	, Va. 2 2	2180 Approximate
			shock, or heart failure. List only immediate Cause (Final	one cause on each line.	2	NEU		_		Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a	F	1000	IVI OIV)	<i>(T</i>		
	Examiner			Due to (or as a con-	sequence or):					
	45	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	sequence of):					
	uted 1 ansit	Examiner	Cause (Disease or injury							
,	n and	Exa	that initiated events resulting in death) Last	Due to (or as a cons	sequence of):					
8760,	ficate be execute physician and is the burial-trans	dicall	· ·	d.						
99	ificat g phy as th									
Box	death certifica attending ph d for use as th	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		75			23d. Date	of delivery
m	death a atte d for	icla	in the past 12 months? 1 □ Yes 2 ☒ No	1□Live birth 2□F 4□Pregnant at time o		⊒Ectopic pregnancy ⊒ Other (s <i>pecify</i>)	·		Mon	th Day Year
0	that the dead by the detached	hys	9 ☐ Unknown	9□ Unknown						
σ,	The law requires that the death certificate be executed tte has been signed by the attending physician and orge 2 should be detached for use as the burial-transit	by P	Part II. Other significant conditions of	ontributing to death but not	resulting in the	inderlying cause giv	en in Part I.	23e. Did to	bacco use contri	bute to the cause of death?
ğ	w require been sig should b		VASC	ULAR		I MI	IN 1	1 1 1 DY	′es 2)∑No :	3 ☐ Probably 4 ☐ Unknown
Records,	s bee	Completed	·	~				24a. Was	an 24b. W	ere autopsy findings available
Re	The lav te has age 2	mo						autop	rmeat? de	rior to completion of cause of sath?
Vital		a l	25. Was case referred to medical				26 Place of De	1 ☐ Yes eath (Check only o	7-3-	☐ Yes 2☐ No
>	Physician: this certificatal director,	OB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2	ER/Outpatie	nt 3 DOA Oth	or V	Home 5 ☐ Resid		r (Specify)
of		n: T	27. Magner of Death	28a. Date of Injury (Month, Day Year	28b. Time o		v at		ow injury occurre	()/
Division	Attanding I r death. actor: After by the funer	atlo	Natural 5 Pending Accident investigation		r) Injury	M 1				
VIS.	Atta acto by th	ifici	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of Injury - A	t home, farm, st	reet, factory, office				r or Rural Route Number,
ā	al or A s after al Dira	Certification:	4 El Homeide	building, etc. (Sp.	вспу)			City or Tow	m, State)	
	To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	ial (29a. Certifier Certifying Ph	ysician: To the best of my	knowledge, deat	h occurred at the tin	ne, date and place	ce, and due to the o	cause(s) and man	ner as stated.
	n 24 na Fu	edical	(Check only 2 Medical Examone)	iner: On the basis of exam and manner stated.	nination and/or in	ivestigation, in my o	pinion, death occ	curred at the time, o	date and place, a	nd due to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed	(Month, Day, Year)
	6		> X TIN Qu	toll mi	\circ	0/	808	4 /) Er Goh	BER 222005
			30. Name and address of person who	completed cause of death (Item 23a) (Type,	Print)	/	1	0	1
			DINESH	PATEL.	11-17-6	012, M	ON TRE	JE 121)	Peck	ENTHE MID
	Sta	ate	31. Date filed (Month, Day, Year)	32. Pogistrar's Si	gnature	beelle		-		20852
	Regist	rar	DEC 30	2005	Nº A					

Martone, Lucille

		Ple	ase Type or Pri					_	_		
		1 - For State Registrar	State of M	larylan		artment of I rtificate of		d Mental H	giene 05	43640	
Physic /Medi		1. Decedent's Name (First, Mid Clara Luci	lle Jessup		lartone				ber 21 200	3. Time of Death	
Exami	ner	4a. Facility Name (If not instituti				4b. City, Town, o	or Location of D	eath	4c. County of De	ath	
		Baltimore Was 5. Social Security Number			enter ast birthday)		Anne Arundel If Under 1 Year If Under 24 Hrs. Months Days Hours Min. March 24,1918 North Carolina Ition 10d. Inside City Limits 1 Yes XXNo 10f. Zip Code 10g. Citizen of What Country? 21076 10g. Citizen of What Country? 21076 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. Specify: White 15b. Kind of Business/Industry 16b. Kind of Business/Industry 16b. Kind of Business/Industry Melissa Hoover Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) The Control of Date Country of Death 4c. Country of Death 4c. Country 6cuntry 9c. Birthplace (State of Foreign Anne Arundel 1d. Anne Arundel 1d. Anne Arunder 1d. Anne Arundel 1d. Anne Arundel 1d. Anne Arundel 1d. Anne Arundel 1d. Anne Arundel 1d. Anne Arundel 1d. Anne Arundel 1d. Anne Arundel 1d. Anne Arundel 1d. Anne Arundel 1d. Anne Arundel 1d. Anne Arundel 1d. Anne Arundel 1d. Anne Arundel 1d. Anne Arunde				
Funeral Director		242-18-7072 Usual Residence of Decedent	1□ M 2(T)F	87	Yrs.			March March	24,1918 No	rth Carolina	
yland how		10a. State 10b. Coun	ty	10c. City	, Town or Lo	cation				10d. Inside City Limits	
e Ma	Director	MD Anne	Arundel		Hanove	er				1 □ Yes XXNo	
ith th	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of What C	Country?	
ath w		896 Timber Ri									
DESITIMOTE, IMATY/SANG Z1Z13-UU35 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be maillish as ance.	by Funerai	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorce	If Yes Give	?		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2🎇 No		' (Specify Yes or N uerto Rican, etc.)		ite, etc.	
2 hou	ted	15. Decede	ent's Education		16a. Dece	dent's Usual Occup	pation		16b. Kind of Business	s/industry	
Z1Z15-UU36 d within 72 hours aff giene. Ir than "natural", or the Medical Exam	Completed	(Specify only high Elementary/Secondary (0-12)	College (1-4or	5+)	(Give life.	kind of work done DO NOT use retire	during most of d)	working		,	
A Minimum Mini	Son	12			Homen	aker			Own Home		
Viand ould be file Mental Hy arked oth attic event	Be	17. Father's Name (First, Middle	e, Last)				18. Mother's l	Name (First, Middle	e, Maiden Sumame)		
Via ould Men warken	မ	David Jessup									
Mar nd 2 sh lith and 27 la m		19a. Informant's Name/Relation									
E, F	i o	Louis Martone 20a. Method of Disposition	(Husband)	20h Bl	896 I	imber Ri	dge Roa	d, Hanove			
Sattimore, sernit. Pages 1 ar appartment of Hea mportant: If them ny injury or other one.		Burial 2 Cremation	3 Removal from State	' i			1	Date	20c. Location - City o	r Town, State	
it. Partimer ritant		4 Donation 5 Other (Mary		Vet. Cem		-23-2005	Crownsvil:	le, MD	
Day permi Depa Impo Impo		21. Signature of Funeral Service	TIPPINSOE		22	Hardesty	Funera	1 Home, H	P.A.		
		23a. Part1. Enter the disease,	or complications that cause	d the death	Do not ent	12 Ridge	Ly Aven	ue, Annar	olis, Mary	Land 21401 Approximate	
Physician /Medical		shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	st only one cause op each I	ine.	onia	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		and or respiratory t		Interval Between Onset and Death	
Examiner				om-	ent	a.					
	Jer	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	b. Oue to (or as	a consequ	ariou of):						
ou, be executed sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events	6								
be exe		resulting in death) Last	Due to (or as	a consequ	ence of):						
oo/o	Icai		d.								
ox oo/	Med	IF FEMALE:	1								
death death e atter	Physician/Medic	23b. Was decedent pre-nant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live birth	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown						23d. Date of delivery Month Day Year	
necolus, r he law requires that e has been signed b ge 2 should be deta	by	Part II. Other significant condit	ions contributing to death b	out not resul	Iting in the ur	nderlying cause giv	en in Part I.		tobacco use contribute to	o the cause of death?	
w requir been si should I	ete							-	_		
Or VICAL NECONATION OF THE LAW INSTRUCTION OF	Completed							24a. Was auto perfo 1 \(\sum \text{Yes}\)		utopsy findings available completion of cause of s 2 No	
sician: 1 sector, prirector, prir	o Be	25. Was case referred to medic examiner?	Hospital:			2 DOA Oth		Death Check only			
offing Phy th. After this funeral d	H .	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendi 2 Accident investi	1 Inpatie 28a. Date of Inju ing (Month, Da	ıry 2	R/Outpatien 28b. Time of Injury	28c. Injur Wor	4 Nursing		dence 6 Other (Spe how injury occurred	ecify)	
To the Hospital or Attending Physician: The law requires that the within 24 hours attendeath. To the Funeral Director: Alier this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Certification:	3 Suicide 6 Could	mined 200. Place of In	ury - At hon c. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (City or To	Street and Number or R wn, State)	ural Route Number,	
he Hospii in 24 hour he Funeri pletely filli	Medical	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ing Physician: To the best I Examiner: On the basis o and manner st	H BAAIIIIIIIIIIIII	rledge, death on and/or inv	occurred at the ting estigation, in my o	ne, date and pla pinion, death oc	ace, and due to the courred at the time,	cause(s) and manner as date and place, and due	s stated. a to the cause(s)	
To t To t Com	₹	29b. Signature and title of certific	E. Will				1365		29d. Date signed (Mont	21,2005	
		30. Name and address of person	who completed cause of d	leath (Item)	23a) (Type, 1	ospital	Drive,	Glen B	urnie, MD	21061	
Sta Registr		31. Date filed (Month, Day, Year		ar's Signatu	ıre	front					

		For State Registrar	State of M	Maryland		rtment d tificate			nd Me		jiene leg. No.	005	4364	
Physic /Medi	cal	Decedent's Name (First, Middle, La Gerald	Duane		Maier				D	Date of Dea Month	Day 3ER		05 3:40 P	
Examil Funeral		4a. Facility Name (If not institution, given Baltimore Washin 5. Social Security Number 6. S	glon He	dical	Lenter ast birthday)	G If Under 1 Y	en'	Buln'	ie Hrs. 10	. Date of Birth	An	0.0	WVNDEL irthplace (State or Fore	
Director		232-54-7090 19 10 10 10 10 10 10 10 10 10 10 10 10 10	XM 2□F	69	Yrs.		ays	Hours	Min. A	(Month, Day pril I	0,193	36	est Virgini	
the Marylan 28a-f ehow notified at	rector	MD Anne Aru	ındel		ofton	10f. Zip Co	nde.				On Citizo	n of What (10d. Inside City Lim 1 ☐ Yes 2X	
ath with 23a or	D	2459 Vineyard Lar	ne.			211					og. Onize	USA	Soundly?	
after des	by Funeral Director	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 XYes 2 If If Yes, Give Year or Dates	?] No	lf 1		of His Cuban	panic Origin , Mexican, F Specify:	n? (Specif Puerto Ric	y Yes or No- can, etc.)		Race - An Black, Wh	nencan Indian, lite, etc. Vhite	
21215-003 sod within 72 hours giene. er then "naturel; i The Medical Exa	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		5+)	(Give k life. D	ent's Usual O and of work of O NOT use n	lone du etir e d)	ring most of			16b. Kind	of Busines	s/Industry	
O post	ပိ	12 17. Father's Name (First, Middle, Last)			Electr	ic fie				First, Middle, I	Maiden S	NASA		
Maryland 212' d 2 should be filed within th and Mental Hygiene. 77 le marked other then traumatic event, the Ma	To Be	Jesse Carl Maier 19a. Informant's Name/Relationship	Cyne Print		10h Mailine	Address (C		Glady:	s Bo	wyer				
72 P = 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		Karin Maier (Wife 20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □)			Vineya	rd	Lane,		fton, 1	MD 21	114	r Town, State	
Baltimore, permit Pages 1 ar Department of Hea Important: If item any injury or othe		4 Donation 5 Other (Specify 21. Signature of Fundamental Service Licen	')		yland 22.	Name and A	ddress	of Facility	-29-3 al Ho	2005 come, P.		svill	e, MD	
Physician / Medical Examiner by physician and bruist-transit true private transit is the private transit.	dicai Examiner	a. art1. Et a the disease, or compshock, or eart failure. List only the shock of eart failure. List only disease or fordition resulting in a ath) Scalantially condition failure are shown in a short underlying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	aDue to (or a.	s a consequence of the consequen	Do not enter	the mode of down well	dying,	such as car	rdiac or re	Annapo espiratory arre	est,		Approximate Interval Between Oriset and Death 410WS Hours Months Months	
Box 6 ath certifi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	déath 3∏E	ctopic pregn Other <i>(specif</i>)					230	i. Date of de Month	elivery Day Year	
cords, P.O. I w requires that the de been signed by the a should be detached t		Part II. Other significant conditions of	Tour (E	but not result	ting in the und	nerlying cause	given	in Part I.				cco use contribute to the cause of death?		
al Reco	Completed by	3								24a. Was ar autopsy perform 1 Yes 2	ned?	24b. Were a prior to death?	utopsy findings available completion of cause of s	
of Vital Physician: The Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			1			Death (C	heck only one	9)			
On Of ding Phys h. After this funeral dii	on; To	27. Manner of Death	28a. Date of Inj	ury 2	R/Outpatient 28b. Time of Injury	3 DOV	Other:	4 Nursin		5 Reside			ecify)	
DIVISION of Vital Records, To the Hospital or Attending Physician: The law requires t within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be or	Certification;	27. Manner of Death t Natural 5 Pending investigation 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? M t Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office									eet and N , State)	lumber or R	ural Route Number,	
he Hospit in 24 hour he Funera pletely fille	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exem	rsicien: To the best iner: On the basis of and manner si	or examinatio	ledge, death on and/or inve	occurred at the stigation, in r	e time, ny opin	date and pl	lace, and occurred a	due to the ca at the time, da	use(s) and te and pla	d manner a	s stated. e to the cause(s)	
To the within To the Comp.	Σ	29b. Signature and title of certifies	'wo	MD		29c. Lid	ense n		44			-	th, Day, Year) 25 2005	
		MARIA GAVIRIA	ompleted cause of	301	Hosp	Hol-	D/	Gle	n 1	Bulnia	e p	1D a	25, 200: 21061	
Sta Registr		31. Date filed (Month, Day, Year)	005 32. Regist	rar's Signatu	ire .									

ORIGINAL

State Registrar

. Registrar's Signature JAN 1 0 2006

DHMH 17 Rev 1/2001

		•	Tor State Registrar	State of Maryland		artment of I			giene 0	i li	3645	
	Dhugiei		1. Decedent's Name (First, Middle, Last)	1 . 11	101			2. Date of De Month		'ear	3. Time of Death	
	Physicia /Medic	al	JAMES 11	10 KELV	170			Dec.	24,2005		4 · 45 A	h
1	Examin	er	4a. Facility Name (If not institution, give s	·			or Location of Dea	ith	4c. County of	Death		
7		ĝ	Beverly Health 5. Social Security Number 6. Sex	7. Age (In yrs. I	ant hirthday)		erick	s. 8. Date of Bir		DERI		
	Funeral Director		-	M 2□ F 84	Yrs.	Months Days			y, Year)	Country	ce (State or Foreig arolina	
	2		Usual Residence of Decedent	04				Apr.9,	1921	50.0	ar offic	_
	rylan		10a. State 10b. County	1	, Town or Lo	cation				10d	. Inside City Limits	
	Ba-1 s	Director	MD Montgo	mery	Gait	hersbu	<u>rg</u>				1 Yes 2 No)
	vith th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country	?	
	death with the Maryland ms 23a or 28a-1 show	srai	217 Booth Str	eet, #204A 2. Was Decedent Ever in U.	6 42 5		0878	See of Ver No	U.S.		Indian	
	ter de	Funerai	11. Marital Status 1 Never Married Marned	Armed Forces? 1 ☑Yes 2 ☐ No	3.	I Yes, specify Cut	pan, Mexican, Pue	Specify Yes or No irto Rican, etc.)	Black,	White, etc		
99	hours after tural', or its al Exemina	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	II	1 ☐ Yes 2√∑ No	Specify:		Specify:	Bla	ck	
2-0036		Completed	15. Decedent's Educ (Specify only highest grade	ation completed	16a. Deced	dent's Usual Occu	pation	orking	16b. Kind of Busi	ness/Indus	stry	_
21	within 72 ene. then "ne	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retire	ed)		MEGM			
2	filed w Hygier other th				Jan	itoria]	1		NIST			_
and	buid be fi Mental H arked oti atic svsr	Be	17. Father's Name (First, Middle, Last) Eddie Oliphant					,	Maiden Sumame			
aryland	should be nd Menta r marked umatic sv	J.	19a. Informant's Name/Relationship (Typ		19h Mailie	na Address /Stree		anie Ol	iphant er, City or Town, Si	ato Zin C	o.de.l	
Z Z	permit. Pages 1 and 2 should be Deperment of Health and Menta Important: If Item 27 is marked sny Injury or other traumatic espace.		Theresa A. Ho		1			ice Rd.	- EX 50	62:2103	20886	
altimore,	It Head	1	20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other pla		Date	Montg 20c. Location - C	ity or Towr	Tage, M.I. n, State	1
Ë	Pages nent of int: If It		1 Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		n Mem F	· 1	3-06	Rockvi	116	MD	
a	permit. Depertir Importe sny Inju		21. Signal of Funeral Service Librarse						FUNERA	L HO	ME, P.A	
<u>m</u>	88558		Cong Z K	monree	n 6,2	46 N. W	lash. S	t., Roci	kville,	MD	20859	
			23a. Part1. Enter the disease, or complice shock, or hear failure. List only on	e cause on each line.					1 1	_ In	pproximate iterval Between	
	Physician		Immediate Cause (Final disease or condition	Den	non	tion	with	Mode	ral de	e i	inset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence ol):	Hill County		U				
8		- i	Sequentially list conditions, b	Due to (or as a consequ	ser ov vilk							
	uted I Insit	Examiner	Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	(
Ć.	exection and rial-tra	Exa	resulting in death) Last	Due to (or as a consequ	uence of):							
8760	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dicai	d									
9	ntifica ing ph e as th		IF FEMALE:									
Вох	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1☐Live birth 2☐Fetal	death 3	Ectopic pregnanc	;y		23d. Date Monti	,	ay Year	
	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of de 9☐ Unknown	eath 5∟	Other (specify) _					,	
P.O.	res that the de signed by the a be detached	h h	Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderlying cause g	ven in Part I.	23e. Did t	obacco use contrib	ute to the	cause of death?	
Vital Records,	luires r sign lid be	d by						1 🗆 '	Yes 2□No 3	☐ Probab	ly 4 Hinknown	1
00	w requir s been s	Completed						24a. Was	an 24b. We	re autops	y lindings available letion of cause of	e
R	The lav	mo				-		autor perfo	rmad? de	or to comp ath? Yes 21		
ita		Be C	25. Was case referred to medical examiner?				26. Place of D	eath (Check only o		3103 20		
Ž	Ø ≥ 5	ဥ	1 □ Yes 2 10 No H	ospital: 1 🗆 Inpatient 2 🗆	ER/Outpatier	t 3 DOA Ot	her: 4 ursing	Home 5 Resid	dence 6 Other	(Specify)		
ב	ding P	on:	27. M. nn. of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of finjury	Wo		28d. Describe	how injury occurred	1		
S	Attending ir death. ector: After by the fune	Icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	290 Plane of lawer At he	ma larm str		Yes 2 No	291 Location /	Ctroot and Months		1	_
Division of	lor A efter Direct In by	Certification;	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	/)	eet, factory, office		City or To	Street and Number vn, State)	or Hural F	route Number,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atler th completely filled in by the funeral		29a. Certifier 1 Certifying Phys	ician: To the best of my kno	wledge, deatl	h occurred at the t	me, date and pla	ce, and due to the	cause(s) and mann	ner as state	ed.	
	in 24 in 24 ine Fu	edical	one)	er: On the basis of examinat and manner stated.	tion and/or in	vestigation, in my	opinion, death oc	curred at the time,	date and place, an	d due to th	e cause(s)	
	To To To To	Σ	29b. Signature and little of certifier		144		se number		29d. Date signed (
•	3		any	ms /	VID	D	58341		12-	16-	-07	
	-	. (3	30. Name and address of son o so	mpleted cause of death (Item	23a) (Type,	TROVAL	muse H	W. Fs	12- rederie	0 11	D 2/7	J
	Sta	te	31. Date filed (Month, Day, Year)	330 egistrar's Signa	Ture /	and D	-11	V -71 -2	Lunc	(در ا	V-170	1/
1	Registi		JAN 0 3 200	16 Marie D		The state of the s						

			1 - For State Registrar	State of M	arylan		artment of rtificate of		nd Mental F	lygiene Reg. No		436L	16
Ę.	Physici	an	Decedent's Name (First, Middle,						2. Date of Month	Da			
	/Medic	:al °	INAYAT MASI 4a. Facility Name (If not institution,				4b. City, Town,	or Location of C	Dec.	28,	2005 County of De		A M
	Examin	er	Shady Grove Adv			Rehah	1	or Location or t	Death		lontgom		
	Funeral		5. Social Security Number	6. Sex 7. Ag		last birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Month,			Birthplace (State o	r Foreign
	Director		133-62-9240	1 ∑ M 2□F	88	Yrs.	Months Days	Hours	Hrs. 8. Date of (Month, March	21,1	917 Pa	kistan	
	land bw		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d, Inside Cit	ty Limits
	Many -f sh	tor	New York Rocklar	ıd	Ora	ngetow	n					1 ☐ Yes	2 ∑ No
	or 288	Olrec	10e. Street and Number		, 020	80 - 0	10f. Zip Code			10g. Cit	izen of What	Country?	
	ath w	ral	7 Ashwood Drive				1091				ted St		
36	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "naturel", or items 23s or 28s-f show event, I're Medical Examinat must be notified at	by Funeral Directo	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:)		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No	ban, Mexican, F	i? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ar Black, Wi Specify: Wh		
5-0036	2 hou	ted	15. Decedent	s Education		16a. Dece	dent's Usual Occu	pation	£	16b. K	ind of Busines		
2121	ithin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work done DO NOT use retir	ed)	r working				
2	filed withi Hygiene. other then		8 17. Father's Name (First, Middle, L	act)		Clerg	yman	19 Motharia	Name (First, Mide			Church	
Maryland	permit. Pages 1 and 2 should be f Department of Health and Mental H Important: if Item 27 is marked of eny Injury or other treumatic even once.	To Be	Labu Mall			1		Hanna	Mall				
a Z	and 2 st ealth and m 27 is n	1	19a. Informant's Name/Relationsh Inayat Masih, Ji			1			or Rural Route Nur . Derwoo				
ē,	s 1 an f Heal item other		20a. Method of Disposition			Place of Dispo	sition (Name of matory or other pla		Date	-		or Town, State	
altimore,	Page Int: If		1 XBurial 2 □ Cremation 4 □ Donation 5 □ Other (Sp				Cemeter	De	cember	Nva	ck, Ne	w York	
a	epartn sporta ny inju		21. Signature of Funeral Jerve L	ichnsed				ess of Facility	DeVol Fu	neral	Home		
m —	80559		M/m/	Un	1				k Drive,		hersbu		
,	Physician		23a. Part / Enter the disease, or of shock for heard failure. List of immediate Cadse (Final disease or condition resulting in death)			er Adv		ing, such as ca	rdiac or respiratory	arrest,		Approximate Interval Bety Onset and D	ween
	/Medical Examiner		resulting in deathy	Due to (or as	a conseq	uence of):							
The second		ner	Sequentially list conditions, if any, leading to immediate cauca. Enter Underlying	b. — Due to (or as	a conseq	цепсе of):							
	certificate be executed ding physicien end ise as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	* ******	uance of							
760,	be ex	cal E	,	Due to (or as	a consaq	derice (ii).							
687	ificate g phys as the			d.									
Вох	eath certific attending p	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnani	34			23d. Date of d	lelivery	
	0 0 0	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant a			Other (specify)			- 1	Month	Day Y	'ear
, P.O	The law requires that the see has been signed by the bege 2 should be detached.		Part II. Other significant condition	s contributing to death t	out not res	ulting in the u	nderlying cause g	ven in Part I.	23e. Di	d tobacco u	ise contribute	to the cause of de	eath?
Vital Records,	w requires been sign should be	ed by							_ 10	Yes 2	∑ No 3 🗆 I	Probably 4 🗆 U	nknown
900	law re as bee 2 sho	Completed							24a. W	as an topsy	24b. Were	autopsy findings a o completion of ca	available
<u> </u>		Соп							pe	rformed? 2⊠ No	death?	es 2 No	230 01
<u> </u>	sician: The certificete irector, peg	Be	25. Was case reterred to medical examiner?	Hospital:			0	har	Death (Check onl				
ō	Phy this al di	To To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Inju	Jry	ER/Outpatien 28b. Time of	N JU DON	4 <u>D</u> , 140(3)	ng Home 5 ☐ Re 28d. Describ			pecify)	
ion	ath. ath. or: After ne funer	atlo	1 ☑Naturał 5 ☐ Pending 2 ☐ Accident investiga	ation	y Year)	Injury		ork?]Yes 2∐No					
Division of	or Attendentiter de Directo	ertification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of In building, e	ury - At ho	ome, farm, str	eet, factory, office			(Street an Town, State		Rural Route Numb	⊅⊕ <i>r</i> ,
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	O	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best	of my kno	wiedge, death	n occurred at the t	ime, date and p	place, and due to the	ne cause(s)	and manner	as stated.	
	the H nin 24 the F nplete	Medical	one)	xaminer: On the basis of and manner st	ated.	tion and/or in			occurred at the tim				
ì	7 V T O T O T O T O T O T O T O T O T O T	~	29b. Signature and title of certifier	7 -				se number				nth, Day, Year)	
•	•		30. Name and address of person w	to completed cause of	taath (Ito-	23a) (Type		8597		Dece	nder 28	3, 2005	
			Shahryar Davari,	M.D., 1522	5 Sh	ady Gr	ove Road	, #208,	Rockvil:	le, Ma	aryland	1 20850	
	Sta Registr		31. Date filed (Month, Day, Year)	2006 32. registr	rar's Signa	F A	all						

			1 = For State Registrar	State	of Marylar		rtment of H tificate of L		Mental Hygie	erne() ()	5	43647
4	Dhysisi		1. Decedent's Name (First, Middle	, Last)					Date of Death Month	Day	Year	3. Time of Death
\$	Physici /Medic		Arossi	Lak	M	ardiros	sian		December			12:53 P.M
	Examin	er	4a. Facility Name (If not institution				4b. City, Town, or	Location of Death		4c. County	of Death	
75		Ď.,	Shady Grove Adv				Rockv:			Mont		
	Funeral Director		5. Social Security Number 220–84–4399	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) May 22,	^(ear) 1922	_Cou	place (State or Foreign ntry) key
	pu 🛾		Usual Residence of Decedent 10a. State 10b. County		10c C	ity, Town or Lo	nation					10d Incide City Limite
	anyla ehov	-										10d. Inside City Limits 1 Yes 2 No
	28a-f	Director	Maryland Montgo	omery	G	aithers	10f. Zip Code		10	0	"	
	a or			m. 4					100	g. Citizen of W	mat Cou	nury ?
	eath	era	9205 Rose Anne		cedent Ever in l	I.S. 13 V	20877	spanic Origin? (Sc	necify Yes or No-	USA 14 Bace	- Ameri	can Indian,
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "netural", or items 23a or 28e-f ehow aumatic event, the Madical Examiner must be notified at	by Funerai	1 □ Never Married 2 □ Marri 3 🛣 Widowed 4 □ Divorced	Armed F	Forces? 2 X No hive		Vas Decedent of Hi Yes, specify Cubar	n, Mexican, Puerto Specify:	Rican, etc.)		k, White,	
ğ	etura cal E	per	15. Decedent	's Education			ent's Usual Occupa		16	3b. Kind of Bu		
21215-0036	nin 7.	Completed	(Specify only highes Elementary/Secondary (0-12)	1	(1-4or 5+)	(Give	kind of work done d OO NOT use retired,	luring most of work)	ang			,
21.	d with	NO.	12	Jonogo	(1 40/ 5/)	Hou	sewife			Hor	ne	
Ö	m - 0 5	Be (17. Father's Name (First, Middle,	Last)				18. Mother's Nam	e (First, Middle, Ma	aiden Surnam	e)	
Maryland	Mental I	To	Aris	Karakch	ian				Arshloos	Mai	leki	an
a	2 sho and and ls m	1	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailin	g Address (Street a	and Number or Rur	al Route Number, (City or Town,	State, Zip	Code)
2	and ealth m 27		Armine Aharonian	n/Daughte					Gaithersb			
ore	P T T T T		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from		Place of Dispo cemetery, cren	sition (Name of natory or other place	θ)	Date 20	c. Location -	City or To	own, State
altimore,	tmen tant:		4 ☐ Donation 5 ☐ Other (Sp		A1:		Cemetery					Maryland
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 is marked any injury or other traumatic e- ones.	ale Property and the Pr	Service of Funeral Service of	Licensee	luli	Ma			Vol Funer			D. 20877
- 100			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the dea	th. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arres	t,		Approximate Interval Between
J. C.	Physician		Immediate Cause (Final disease or condition	Rena	al Failu	ıre						Onset and Death 1 week
	/Medical		resulting in death)	Due to	(or as a conse	quence of):						
н	Examiner		Sequentially list conditions,	D	umonia							2 weeks
	p tis	Examiner	if any, leading to immediate cause. Enter Underlying	Due to	o (or as a conse	quence of):						
	cate be executed physician and the burial-transit	хап	Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a conse	quence of):						
8760,	be ey ician buria	aiE			(0) 40 4 00/100/	quonoc or).						
387	phys phys s the	dicai	17	d	<u> </u>							
×	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	ician/Me	IF FEMALE:	23c. If yes, or	utcome of pregn	ancy				23d. Date	of deliv	20/
Box	atter for L	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 Fet	al death 3	Ectopic pregnancy Other (specify)			Mon		Day Year
o.	the d ny the ached	Physi	1 □ Yes 2 🖾 No 9 □ Unknown	9□ Unki								
<u>a</u>	res that the de signed by the a be detached f	by PI	Part II. Other significant condition	ns contributing to	death but not re	sulting in the ur	iderlying cause give	en in Part I.	23e. Did toba	cco use contri	bute to t	he cause of death?
Vital Records,	w require been sig should bi								1 ☐ Yes	2 X No	3 🗌 Prot	pably 4 □Unknown
000	law reas bee	Completed							24a. Was an	24b. W	/ere auto	ppsy findings available mpletion of cause of
Re	The la	mo							autopsy	ed? d	eath?	
ta		BeC	25. Was case referred to medical	- 1				26 Place of Deat	1 Yes 2∑ h (Check only one)	No 1	☐ Yes	2LJ N0
	S S D	To B	examiner? 1 ☐ Yes 2█ No	Hospital: 1 🗵	Inpatient 2] ER/Outpatien	3 DOA Othe	ar	ome 5 Residen	ce 6 □Othe	r (Specif	ν)
0	fing Ph		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date	of Injury nth, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe how			,,
0	tendir Jeath. tor: Af the fur	atic	2 Accident investig	ation	·····, - , · · ·,	,.,		res 2 □ No				
Division of	or Atti after de Directe in by ti	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 286. Plac	e of Injury - At I		eet, factory, office		28f. Location (Stre City or Town,		er or Rura	al Route Number,
	rital c											
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) 12 Certifyin 2 Medical	Examiner: On the	ne best of my kn bacis of examin neer stated.	owledge, death ation and/or inv	occurred at the tim restigation, in my op	e, date and place, pinion, death occur	and due to the cau red at the time, date	se(s) and mar and place, a	nner as s nd due to	tated. the cause(s)
	roth Mithin Foth compl	₩	29b. Signature and title of certifier				29c. License	number	290	I. Date signed	(Month,	Day, Year)
)	2		>UUUMA	TIT P. I	CURUNI	UA IN	11 .04	6187	1) 5	CRMA	FR	28,2005
			30. Name and address of person		-					100	-	
			Ajit Kuruvilla,	M.D., 11	125 Roc	kville	Pike,Sui	te 208, I	Rockville	, Mary	land	20850
79	Sta	te	31. Date filed (Month, Day, Year)									
	Registr	ar	JAN 0 3	2006	Registrar's Sign	· Jagoria	68					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Ophelia December 11,2005 12:20PM Marian Mercer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly Prince Georges Gladys Spellman Nursing Home
5. Social Security Number 6. Sex 7. Age (In yrs. last bir. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 □ M 2 🖫 F 84 Director 11,1921 250-24-1985 N.C. Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits works r 28a-f show 1 ☐ Yes 2 ☐ No Director D.C. Washington 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or styling or other traumatic event, the Medical Examiner must be once. 315 Bryant St. N.E. 20002 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cashier Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lucious Hobson Beulah Crosby 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Rice/son P.O. Box 113 Dayton MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Mem.Park 12/19/05 Landover, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hodges and Edwards 21. Signature o Funeral Service Licensee 3910 Silver Hill RD. Suitland, MD. Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Partr. Effective uses shock, or heart failu Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner Infected Decubitus Sequentially list conditions, if any, loading to initiourist cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se a nonecouanna of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Bed Bound Due to (or as a consequence of) physicien a s the burial-1 P.O. Box 68760 Physician/Medical Severe Flexion Contractures use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown this certificete has been si al director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 Mo 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1X Natural 5 Pending 1 TYes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATUA cuurs 31. Date filed (Month, Day, Year) 3. Registrar's Signature State JAN 1 0 2006 Registrar

			1 - For State Registrar	State of I	Maryland / Dep Ce	ertificate		nd Mental	Hygier Reg.	LUU	5	43649
	Physici	an	1. Decedent's Name (First, Middle, Larnell Nealy	Last)				Mon	of Death th ember	Day 25 2	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution,	give street and number	er)	4b. City, Tow	n, or Location of			4c. County	005 of Death	2:30 P M
40 (A)	LXuiiiii		Woodside Center	GHC			Spring			Mont	gome	ery
	Funeral Director		5. Social Security Number 458-07-8095	6. Sex 7. 13X M 2 ☐ F	Age (In yrs. last birthday 86 Yrs.	Months Da		Min. 8. Date (Mon	of Birth	ar) 1919	9. Birthi Cou Te	place (State or Foreign ntry) XAS
95	D		Usual Residence of Decedent					Jop		, ->-/		
	arylar ahow	'n	10a. State 10b. County		10c. City, Town or I							10d. Inside City Limits 1 XYes 2 No
	the M	Directo	Maryland Montgo	omery	Silver S	pring 10f. Zip Cod	le		10g.	Citizen of W	Vhat Cou	
	h with	ID I	9722 Woodland I	rive		209				nited		
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "satural", or Iteme 23a or 28a-f ahow any injury or other traumatic event, the Madical Examinar must be notified a once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ X Marrie		□ No	. Was Decedent of Yes, specify C		in? (Specity Yes Puerto Rican, et	or No-	Blac	e - Ameri k, White,	
ş	hours tural		3 Widowed 4 Divorced	Year or Date	unknown	edent's Usual Oc	cupation		16b	. Kind of Bu		
21215-0036	thin 72 8.	Completed	(Specify only highest Elementary/Secondary (0-12)		(Giv	e kind of work do DO NOT use re	ne during most tired)	of working				,
7	led wil lygien har th		12		Pos	tal Cler		d- No (Eins A	Part No.	Post		ce
and	d be fi	To Be	17. Father's Name (First, Middle, L Robert Nealy	ast)				's Name <i>(First, N</i> die Well		дөп Ѕитат	Θ)	
ary	shoul and Me s marl	F	19a. Informant's Name/Relationshi	ip (Type, Print)	19b. Mai			r or Rural Route i		ty or Town,	State, Zij	o Code)
, Ma	and 2 ealth a m 27 i		Nadine Nealy	(wife)	- Tritoria Africa Commence - The Commence -			e, Silve	***			20910
saitimore,	I it it		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		20b. Place of Disposers			Date 12 / 20 / 05		. Location -		
	artmer artmer ortant injury		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L		Chesape			McGuire				Maryland
n	Depar Impo		(undre à	Showyo	100-			ve. N.W.				
- 87	1500		23a. Part1. Enter the disease, or c shock, or heart failure. List of	complications that cau	sed the death. Do not e	nter the mode of	dying, such as o	cardiac or respira	tory arrest,			Approximate Interval Between
No.	Physician		Immediate Cause (Final disease or condition resulting in death)		ic Coma							Onset and Death 5 days
	/Medical Examiner		Tosailing w. goaliny		as a consequence of): static Carc	inoma Ii	vor					2
l.	to the second	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	U	as a consequence of):	IIIOma Li	VET					2 mos.
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	U	er Fundus of as a consequence of):	E Stomac	h				=4	3 mos.
8/60,	cate be executed physician and the burial-transit			Due to (or	as a consequence or).							
189	ifficate g phys as the	edic		d			- 27				-	
. Box	es that the death certifics igned by the attending pt be detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	4□Pregnan	n 2 ☐ Fetal death 3 It at time of death 5	□Ectopic pregna				23d. Date Mor		ery Day Year
r O	at the d by the etache	Phys	9 Unknown	9□ Unknow					0:1.		•• • • • •	
ecords,	w requires that been signed b should be deta	þ	Part II. Other significant condition Carcinoma Bla		n but not resulting in the	underlying cause	given in Part I.		. Did tobacc			he cause of death? bably 4 ⊡Unknown
Hec	The law ate has b page 2 sl	Completed	Hypertensive	Cardiovaso	cular Diseas	se			Was an autopsy performed Yes 2 🛣	l? d	Vere auto prior to co leath? □ Yes	opsy findings available impletion of cause of 2 No
VItal H	Physician: rthis certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			04	of Death (Check		are mile		
ō	this ald	n: To	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date of I	Injury 28b. Time	BIT JE DOA	njury at Work?	sing Home 5 28d. Des		njury occurr		(y)
0	tending Jeath. tor; Afte the fun	atlo	1 XNatural 5 Pending 2 Accident investiga	ation	Day Year) Injury		Work? 1 ∐Yes 2 ∐N	lo				
DIVISION	2007	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and 288. Place of	Injury - At home, farm, s , etc. (Specify)	street, factory, offi	ice		ition (Street or Town, St		er or Rura	al Route Number,
	To the Hospital or A within 24 hours after To the Funeral Directonpletely filled in by	edical	29a. Certifier 1 Certifying (Check only one)	Physicien: To the be xaminer: On the basi and manner	est of my knowledge, dea is of examination and/or r stated.	ath occurred at th investigation, in n	e time, date and ny opinion, death	d place, and due th occurred at the	to the cause time, date	e(s) and ma and place, a	nner as s and due to	stated. the cause(s)
	To the within To the complete	Σ	29b. Signature and title of certifier	0.4			ense number			Date signed		
ł	140		2 lew angl	2 Beltu	of do-at-fine grant or		25586		De	cember	r 28	, 2005
			30. Name and address of person w E. Vaughn Bel		of death (Item 23a) (Type 1629 Colum		d, N.W.,	, Ste. 3	34_ W	ash. I	D.C.	20009
4	Sta Registi		31. Date filed (Month, Day, Year) JAN 0 3	2006 32 Reg	istrar's Signature	and i						

State of Maryland / [Department of Health and	Mental Hygiene
-----------------------	--------------------------	----------------

Certificate of Death Reg. No. 2. Date of Death Month December 30, 2005 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 10:15 p_M Charles Robert Norwood /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8118 Cambridge Drive Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 180M 2□ F 216-22-1758 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or items 23s or 28s-f show the Medical Exeminer must be notified at Frederick 1 ☐ Yes 2 ☑ No Maryland Frederick Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8118 Cambridge Drive 21704 U.S.A. death Funeral Was Decedent Ever in U.S. Armed Forces? 1 Pres 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iter any injury or other traumatic event, the Medical Exercities 2016. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 E No Specify: Specify ģ 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Research Animal caretaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles M. Norwood Laura Craver ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Norwood - wife 8118 Cambridge Drive, Frederick, Maryland 21704 20a. Methed of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State 1-4-2006 Resthaven Memorial Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Libensee 22. Name and Address of Facility Stauffer Funeral Home Sharon 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final of Bladde Physician iransitional disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. tf yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed? certificate 1 Yes 2. No 1 Tes 2□ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred 1. Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 32245 1/3/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederich 21702 31. Date filed (Month, Day) 2006^{32. Regultrar's Signature} State Registrar

hysici	an	1. Decedent's Name (First, Middle, La.	_	0.137						2. Date of Deat		7 ~ Ye	ar_ :	3. Time of De
/Medic			Lynn	O'Ne	eal					Decembe	_			9:15
xamir	ner	4a. Fecility Name (If not institution, give		9r)				Location o	of Death			County of D		
neral		31561 Johnson Ro		Age (In yrs.	last birthday)	If Under		If Under:	24 Hrs.	8. Date of Birth		Vicom:	Birthplac	e (State or Fo
ector		217-54-5000 19usual Residence of Decedent	□ M 2 🔏 F	57	Yrs.	Months	Days	Hours	Min.	11/24/1	948	l	Country, Mary.	land
E OM		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d.	Inside City L
	cto	Maryland Wicomi	.co	5	Salisbu	ıry								1 Yes 2
D BE	Directo	10e. Street and Number	.a			10f. Zip	Code 1804	1		10	_	en of What	Country	?
Tural T	erai	31561 Johnson Roa	12. Was Decede	nt Ever in II	C 12.1				-in2 (Coo	aifu Vaa as Na		JSA 4. Race - A	mariana	Indian
avent, the Madical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1 Yes 2[If Yes, Give Year or Date	is? ∑ No		f Yes, speci		Specify:	gin? (Spe i, Puerto I	cify Yes or No- Rican, etc.)			hite, etc white	
岩	led	15. Decedent's Ed	ducation	•	16a. Deced	dent's Usual	Occupa	tion			16b. Kin	d of Busine	ss/Indus	itry
Wad	Completed by	(Specify only highest gra	College (1-4c	or 5+)	(Give	kind of work DO NOT use	k done d e retired)	uring most	t of workii	ng				•
릨	ь С	Elementary/Secondary (0-12)	2		Pract	ical	Nurs	se			He	ealth	Care	e
raumatic avent, In	To Be	17. Father's Name (First, Middle, Last) James Leroy Furr								(First, Middle, N Elizab		,	3	
3 5	Ì	19a. Informant's Name/Relationship (Robert D. O'Neal	* * * * * * * * * * * * * * * * * * * *	and						Route Number, alisbury				ode)
any injury or othe		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 1)		te Sal	Place of Dispo cometery, crem ISDURY	sition (Nam natory or oth Crem	e of her place ator	2) 1	.2/19	ate 2 /05		ation - City Lisbur		
nu iuin	<	2 Str. ture of Funeral Service Liner		CFS	P 22	Name and	way	Funei	cal E	Home Pro	fess	sional	L Ass	sociat:
	Н	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that days	sed the deat	h. Do not ente	er the mode	of dying	, such as	cardiac o	Salisb r respiratory arre	st,	ב עומי	A	terval Betwee
cian dical diner	iner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	as a conseq	uence of):	40 CI	ARL	DIA	/	NFAR	C71	on		nset and Deat
as the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or and d.	as a conseq	uence of):									
ached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta at time of d	Ideath 3	Ectopic pre Other (spe					23	3d. Date of Month	delivery Da	y Year
should be detached	by	Part II. Other significant conditions of	OIA GE	but not resi	-	nderlying car				23e. Did toba				ause of death
36.2	Completed									24a. Was an autopsy perform	r	24b. Were prior death 1 🗌 Y	to compli !?	findings availation of cause
rector, pag	Be	25. Was case referred to medical examiner?	11						of Death	(Check only one)			
al di	2	1 ☐ Ves 2 ☐ No 27. Manner of Death	Hospital: 1 ☐ Inpa		ER/Outpatien		Other	4 U Nur		ne 5 X Resider			pecify)	
fune	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			28b. Time of Injury	м		at ? es 2 □ N		8d. Describe how	w injury	occurred		
completely filled in by the		4 Homicide determined	building,	etc. (Specify	v)					8f. Location (Str. City or Town,	State)			
completely filled in	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the be niner: On the basis and manner	of examina	wledge, death tion and/or inv	occurred a restigation, i	t the time in my opi	e, date and inion, deat	i place, a h occurre	nd due to the car d at the time, da	use(s) a te and p	nd manner place, and c	as state	d. e cause(s)
d CO CO	Σ	29b. Signature and title of certifier				29c.	License.	number		29	d. Date	signed (Mo	onth, Day	r, Year)
		- Cla	Fi d	M.	n .		105	0)	59	RO S	12	119	las	
1			Eur									/ /	/ { / -	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [1] 5 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year O'Mulley 09:50 AM December 27, 2005 4c. County of Death Michael Town or Location of Death 4a. Facility Name (If not institution, give street and number) Johns Hopkins altimore If Under 24 Hz 5. Social Security Number ge (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
July 25, 1 Birthplace (State or Foreign Country) Days Hours XXM 2□F 64 Yrs 1941 Connecticut 032-30-3969 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√XNo MD Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 Lamp Post Lane 21108 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No White Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Elementary/Secondary (0-12)

Physician

/Medical

Examiner

Funeral

Director

23a or 28a-f ehow

or items

"netural",

other then

permit Pages 1 end 2 should be file Depariment of Health and Mental Hy Imporiant: If Item 27 ie marked othe any injury or other traumatic event 9008.

Physician

/Medical

Examiner

attending physicien and for use as the burial-transit

detached for use

funeral director.

filled in by

After

s after dea.

within 24 hours a
To the Funeral C
completely filled

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O.

Box 68760.

the Medical Examiner must be notified at

Director

Funerai

þ

Completed

Be

Examiner

Physician/Medical

þ

Completed

Be

မ

Certification:

Medicai

29a. Certifier

the Maryland

death

filed within 72 hours after

Baltimore, Maryland 21215-0036

18. Mother's Name (First, Middle, Maiden Surname)

Peter F. O'Malley 19a. Informant's Name/Relationship (Type, Print)

Eleanor Zickell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Mary Frances O'Malley (Wife) 1000 Lamp Post Lane, Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Our Lady of Fields 12-30-2005 Millersville, MD

Court Administrator

21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Meumonia Due to (or as a consequence of) Cancer Due to (or as a consequence of)

Kenal

Due to (or as a consequence of)

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death

College (1-4or 5+)

4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

State of Maryland

Year

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an

1 XYes

23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 2 🗌 No

1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

26. Place of Death (Check only one)

Location (Street and Number or Rural Route Number, City or Town, State)

25. Was case referred to medical examiner? Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred

27. Manner of Death 1 XNatural 2 ☐ Accident 5 Pending investigation 3 🗌 Suicide 6 Could not be determined 4 🗌 Homicide

and manner stated

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death coourned at the time, date and place and due to the cause(s) and was more as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number Res- 000

Medical Doctor 30. Name and addres of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day Year) **DEC 3 0 2005**



DHMH 17 Rev 1/2001

ORIGINAL

	1	State Registrar	of Maryland / Depa	rtificate of l		F	Reg. No.	43653
sicia	n	Decedent's Name (First, Middle, Last) Joseph N. Pokorni				2. Date of Dea Month Decembe	Day Ye	3. Time of Death 05 1:20 p M
edica mine	_	a. Facility Name (If not institution, give street and i	number)	4b. City, Town, or	r Location of Death)	4c. County of [
		Washington Adventist H	-	Takoma			Montge	
ral tor		. Social Security Number 338-05-7793 6. Sex 1™ M 2□ F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min,	8. Date of Birtl (Month, Day Nov. 1	h, Year) 2, 1911	Birthplace (State or Foreigr Country) Illinois
6	-	Jsual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	cto	Maryland Prince George	's College E	ark				1 ☐ Yes 34☐ No
ODC8.	Director	Oe. Street and Number		10f. Zip Code			10g. Citizen of Wha	t Country?
	era	9246 Limestone Place 1. Marital Status 12. Was Di	ecedent Ever in U.S. 13.	20740 Was Decedent of H	ispanic Origin? (S	pacify Vas or No-	14 Bace - 1	USA American Indian,
1	by Funeral	Armed 1 Never Married 2 Married 1 Yes.	Forces? s 21X No	if Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	Rican, etc.)	Black, V	White, etc. White
	Completed	15. Decedent's Education (Specify only highest grade complete	d) 16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	during most of wor	king	16b. Kind of Busin	ess/Industry
	E	Elementary/Secondary (0-12) College	(1-4or 5+) Mac	hinist			Own	Business
	Bec	17. Father's Name (First, Middle, Last)					Maiden Sumame)	
	္	Robert Pokorni	101 11 11	11122		ne Jawo:		
Ì		19a. Informant's Name/Relationship (Type, Print) Judith Lee Pokorni/ Da					or, City or Town, Sta e Park, M	
В		20a. Method of Disposition T Burial 2 Cremation 3 Removal fro	20b. Place of Dispo cemetery, cre		Jan.	Date 3,	20c. Location - City	or Town, State
	+	`4 □Donation 5 □ Other (Specify) 21. Signature of Fineral Service Licensee		-	200			Illinois
Mike	1	1 Unchew C	le 50	ancis J. O Univers	Collins sity Blvd	Funeral I, W, Si	Home Inc lver Spri	ng, MD 20901
il r		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of immediate Cause (Final disease or condition resulting in death)	It caused the death. Do not en n each line. 1 yo card (ter the mode of dyin	farch	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Exa	cause. Enter Underlyin Cause (Disease or injury that initiated events c.	to (or as a consequence of): to (or as a consequence of):					
1	dlcal	d.						
- 1	Physician/Me	in the past 12 months?		Ectopic pregnancy	′		23d. Date of Month	delivery Day Year
	2	Part II. Other significant conditions contributing to	death but not resulting in the u	inderlying cause giv	en in Part I.	23e. Did to		te to the cause of death? Probably 4 Unknown
	ompleted						rmed? prior deat	
	O	25. Was case referred to medical	243		26. Place of Dea	1 ☐ Yes ith (Check only o	2 1 No 1 □	Yes 2 No
1	on: To B	27. Manner of Death 28a. Da	Inpatient 2 R/Outpatient te of Injury Conth, Day Year)		er: 4 ☐ Nursing H	ome 5 Resid	dence 6 Other (Specify)
	ertification;	2 Accident investigation 3 Suicide 6 Could not be	ace of Injury - At home, farm, st ilding, etc. (Specify)		Yes 2 □ No	28f. Location (S City or Tow		r Rural Route Number,
- 1	edical Ce	(Check only 2 Medical Examiner: On the	the best of my knowledge, deal a basis of examination and/or in	h occurred at the tir	me, date and place	, and due to the orred at the time, o	cause(s) and manne date and place, and	or as stated. due to the cause(s)
	Mec	29b. Signature and title of certifier	A Heardy M	29c. Licens	e number		29d. Date signed (A	fonth, Day, Year)
		1/t. 7 m).	ERILIA	Print) Washung	14848		12/26	05
	ŀ	30. Name and address of person who completed c	ause of death (Item 23a) (Type,	Print)		1 1 1	260	Correll Learn Park r 2091
	- 1		IND. ER	A A / 1	1	J - J -		

State of Maryland / Department of Health and Mental Hygiene state Registre MEND#23aP1+2per MD1/6/06, HW, McCo Certificate of Death Reg. Wo. Decedent's Name (First, Middle, Last) 2. Date of Death December 25, **Physician** James Fielding Pierce 2005 9:18 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 24, 9. Birthplace (State pr Foreign Country Washington D.C 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□F 1947 Director 577-62-6837 58 Yrs. Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other then "natural", or items 23a or 28a-f shower, the Wadical Examiner must be notified at 1 Yes 2 No Directo Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10802 McComas Court Items 23a 20895 USA Funeral fited within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specity: SpecifyWhite þ 3 ☐ Widowed 4 ★ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Coltege (1-4or 5+) Elementary/Secondary (0-12) Manager Accounting permit. Pages 1 and 2 should be filed w
Depertment of Health and Mental Hygie
Important: If Item 27 is marked other it
eny injury or other traumatic event, in
once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James B. Pierce Patricia Garrison 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Gallivan/ Brother-in-law 9912 Fleming Avenue, Bethesda, MD 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 28 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2005 Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis Affess collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 ske 23a. Part1. Enter the disease, or comshock, or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Cardiac Arrest /Medical Due to (or as a consequence of): **Examiner** Atherosclerotic Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualti (or as a consequence of): Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Alzheimer's Due to (or as a consequence of) Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 Hunknown 1 ☐ Yes 2 ☐ No Cerebellar degeneration 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 X No funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☑ Yes 2 ☐ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After s after dea. 1 X Natural Injury 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospitat within 24 hours a To the Funeral D filled (a) Certifying Physician: To the best of my knowledge, death oncurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D53691 December 27, 2005 30. Name and a press of person who completed cause of death (Item 23a) (Type, Print) Ajay Reddy, M.D. 6320 Democracy Blvd, Bethesda, MD 20817 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2 9 2005 Registrar

				artment of Health and Men		iene 05	43655
ı	Dhysiai	an l	Decedent's Name (First, Middle, Last)		Date of Death		3. Time of Death
	Physici /Medio		ALTA WILMA PATTERSON	De	cember		9:45 PM
	Examin	er	4a. Facility Name (If not institution, give street and number) Wilson Health Care Center	4b. City, Town, or Location of Death Gaithersburg		4c. County of Deat	
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		Date of Birth		
	Funeral Director		217-30-5174 1□M 2♥F 90 Yrs.	Months Days Hours Min	(Month Day, pril 1	,1915 PA	hplace (State or Foreign untry)
	ס		Usual Residence of Decedent		•		
	show	ž	10a. State 10b. County 10c. City, Town or L				10d. Inside City Limits 1 X Yes 2 ☐ No
	28e-f	Director	Md. Montgomery Gaithers	ourg 10f. Zip Code	10	0g. Citizen of What Co	21
	3a or		407 Russell Ave #716	20877		Jnited Stat	
	death	Funeral		Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica		14. Race - Ame	rican Indian,
ð	or lite		1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 No Specify:	ari, G io.,	Black, White	hite
9500-612	e filed within 72 hours after death with the Maryland al Hygiene. other then "neturel", or liems 23a or 28e-f show vent, the Medical Exam her must be notified at	ed by		dent's Usual Occupation			
Ç	n "ne	Completed	(Specify only highest grade completed) (Givi	kind of work done during most of working DO NOT use retired)		16b. Kind of Business/	industry
717	filed within Hygiene. Wher then "	Com	Elementary/Secondary (0-12) College (1-4or 5+) 12 Admin	strative Assistant		College	
9	be filed al Hygi d other	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name (Fin			
Maryland 21	should be ind Mental s marked o	우	Oliver Franklin Patterson	Edna Grac			
<u>a</u>	d 2 st th and 17 Is n treun			ng Address <i>(Street</i> an <i>d Number or Rural Ro</i> Lendall Lane Frederi			
<u>ი</u>	tem 27		20a. Method of Disposition 20b. Place of Disp	sition (Name of Date		20c. Location - City or	
ē	permit. Pages 1 and 2 should be 1 Department of Health and Mental I Importent: If Item 27 Is marked of any injury or other treumatic even once.		I LA bunai 2 U Cremation 3 U Hemovat from State I	11 Cemetery Jan. 5,	•	Suitland,	MD
Baltimore,	Departm Departm Importer any inju			2 , 2000		ral Home	
<u>n</u>	89789			East Deer Park Dr.	Gaith	ersburg, M	d. 20877
			23a. Fart1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or res	spiratory arre	est,	Approximate Interval Between Onset and Death,
le	Physician		Immediate Cause (Final disease or condition resulting in death)	- pertonation			5 weeks
U	/Medical Examiner		Due to (or as a consequence of):	1			
		Jer	Sequentially list conditions, if any, reading to immediate b. Due to (or as a consequence of).	- 1			
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.				
Ď,	cate be executed oblysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):				
09/8	icate b physic s the b	dical	d				
×	death certific e attending p d for use as 1	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deli	very
Box	death a atter d for u	iciar	in the past 12 months? 1 Ves 2 No. 1 Pregnant at time of death 5	DEctopic pregnancy Other (specify)		Month	Day Year
J.		hys	9 Unknown				
ທົ	iaw requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the			acco use contribute to	
ord	w require been si should I	eted	chronic myelomoniane	/eukomia	1 🗌 Ye:	s 2 2√1 0 3 □ Pro	obably 4 Unknown
ç	9 4 9	Completed			24a. Was an autopsy perform	y prior to d	topsy findings available completion of cause of
Vital Record	icien: The certificate harector, page	e Co	25. Was case referred to medical		1 Yes 2	Yes 1 □ Yes	2 No
	s certific director,	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death (Chart 3 DOA Other: 4 Trursing Home		nce 6 Other (Spec	nife)
ō	g Phys ter this neral dir	P-1	27. Manner of Death 28a. Date of Injury 28b. Time of			w injury occurred	ary)
Division of	uttendin death. ctor: Afr y the fur	atlo	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Ĭ	ol or Attending Pater death. I Director: After the in by the funera	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	eet, factory, office 28f. I	Location (Str. City or Town,	reet and Number or Ru , State)	ral Route Number,
	pitel ours a lerel C		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, dea	a cooursed at the time, date and place, and	due to the se		stated
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific, completely filled in by the funeral director,	edical	(Check only one) Office (Check only one) Office (Check only one) Office (Check only one) Office (Check only one)	vestigation, in my opinion, death occurred at	t the time, da	ite and place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Month	
)			John La Mulguela mi	D19294	,	December	31,2005
,	8		30. Name and address of person who completed cause of death (Item 23a) Trype		11.1	2.676	31,2005
	Ch	10	John / R. Melwick 911 / W137 // / / / / / / / / / / / / / / / / /	of. Caithuilung	ing.	20x //	
	Sta Registi		31. Date liled (Month, Day, Year) JAN 0 3 2006 32 Registrar's Signature	arke			

		-	1 - State Registrar	State of	Marylan		artment of tificate o		and Me	ental Hygi	ene) 05	4365	56
			1. Decedent's Name (First, Middle, Last)						2. Date of Death		3. Time of	Death
	Physicia		JESSIE R. PARI	SE						Month DECEMBER	Day Year 29, 2005	7:40	P^{M}
	/Medic Examin		4a. Facility Name (If not institution, give		er)		4b. City, Tow	n, or Location of			4c. County of Dea	ith	
	LAGITITI	51	12309 TREETOP DRIVE #2	1			SILVER S	PRING			MONTGOMERY		
	Funeral		5. Social Security Number 6. Se		Age (In yrs.	last birthday)	If Under 1 Ye	ar If Under	24 Hrs.	8. Date of Birth (Month, Day,		thplace (State of	r Foreian
	Director]M 2ÅF	78	Yrs.	Months Da	ys Hours	Min.	(Month, Day, 12/09/1921	Year) C 7 WASH	ountry) INGTON, D	
			Usual Residence of Decedent										
	yland		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside Ci	ty Limits
	Mar fast	tor	MARYLAND MONTGOMERY		SILV	ER SPRI	NG					1 ☐ Yes	2 📉 No
	the 28e	Director	10e. Street and Number				10f. Zip Cod	le		10	g. Citizen of What C	ountry?	-
	Sa o		12309 TREETOP DRIVE #2	1			2090	1/.			U.S.A.		
	death with the Maryland ms 23a or 28e-f show r must be rollined at	Funeral	11. Marital Status	12. Was Decede	ent Ever in U	.S. 13. 1		of Hispanic Orig	gin? (Spec		14. Race - Am	encan Indian.	
	fter c	ᆵ	1 ☐ Never Married 2 ☐ Married	Armed Force 1 ☐ Yes 2			f Yes, specify C	uban, Mexican	, Puerto P	lican, etc.)	Black, Whi		
<u> </u>	urs a	β	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Date			1 ☐ Yes 2 🖾 i	No Specify:			Specify:	/HITE	
ğ	ture	ed	15. Decedent's Edi	ucation		16a. Deced	dent's Usual Oc	cupation		1	6b. Kind of Business		
5	in 72	olet	(Specify only highest grad	de completed)		(Give	kind of work do DO NOT use re	ne durina mosi	t of workin	g		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
21215-0036	filed within 72 hours after Hygiene. ther than "neturel", or Ite ant, Ite Medical Examina	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	SECRET	ARY				CLERICAL		
	filed Hyg ther		17. Father's Name (First, Middle, Last)			1 525		18. Mothe	r's Name		faiden Sumame)		
Maryland	2 should be filed within 72 hours after death with the Marylan and Mental Hyghens is marked other than "returel", or liems 23a or 28e-f show eumatic event, it a Medical Examination may be redified at	o Be	MYER RIFK	TN				ANNA		S	HOPAVOLOV		
2	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic evonce.	ြ	19a. Informant's Name/Relationship (T			19b. Mailir	na Address (Str		er or Rural		City or Town, State,	Zip Code)	
<u>8</u>	d2 sth ar th ar treu		TERRI M. CANTER/DAUGHT			1.					ARYLAND 2104	,	
e)	Heal Heal Ther		20a. Method of Disposition	EK	20b. F	Place of Dispo	sition (Name o	f			20c. Location - City or		
کار	Se = 50		1 ⊠ Burial 2 □ Cremation 3 □		ate C	cemetery, crer	natory or other	place)		1			
altimore,	tmer tent tent ijury		`4 □Donation 5 □ Other (Specify,		MAR			EMETERY (2006 CI	ROWNSVILLE,	MARYLAND	
Ba	ermi Depar D		21. Signature of Funeral Service Licens	0	ď			Idress of Facilit	UTME	S-RINALDI	FUNERAL HON	Œ, INC.	201
_	70 F # 04		* Whanda	Zuale	way						SPRING, MAI	RYLAND 209	104
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	olications that cau one cause on eac	ised the deat th line.	th. Do not ent	er the mode of	dying, such as	cardiac or	respiratory arre	st,	Approximat Interval Bet	ween
	Pnysician		Immediate Cause (Final disease or condition		HEAG	27	NIS/	EASE	_			Onset and I	Jeath
	/Medical		resulting in death)	Due to (or	as a conseq	quence of):		- / 1 - 0					
	Examiner		Sequentially list conditions	b									
-	P ==	ner	if any, leading to immediate cause. Enter Underlying		as a conseq	quence of):							
	cuted nd ransi	Examiner	that initiated events	C									
ó	an ar	EX	resulting in death) Last	Due to (or	as a conseq	quence of):							
8760,	cate be executed physician and the burial-transit	dical		d									
မ	tiffica ig ph as th	led											
Вох	andir use	Z	230. Was decedent pregnant	23c. If yes, outco	me of pregna h 2 ☐ Feta		Totalia arasa				23d. Date of de	livery	
Ω.	deatl e atte d for	icia	in the past 12 months?	4☐Pregnar	nt at time of c]Ectopic pregna] Other (s <i>pecif</i> y				Month	Day '	Year
0	t the	Physician/Me	9 Unknown	9□ Unknow	m								
Division of Vital Records, P.O.	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use a	by P	Part II. Other significant conditions co	ontributing to dea	th but not res	sulting in the u	nderlying cause	given in Part I.		23e. Did tob	acco use contribute t	o the cause of d	eath?
<u>5</u>	quire n sig	d b								1 □ Ye	s 2□No 3□P	robably 4 🖫	nknown
00	w requir been s should	Completed								24a. Was an	24b Were a	utopsy findings	available
Re	The law cate has page 2	m d								autopsy	prior to death?	completion of c	ause of
a	icien: Th certificate rector, pag		Tor Manager							_1		s 2 No	
⋚	ysicien: is certific director,	Be	25. Was case referred to medical examiner?	Hospital:				Othor		(Check only one			
of	Phys this al dii	. To	1 ☐ Yes 2 ŶNo 27. Mannerof Death	1 ☐ Ing 28a. Date of	-	28b. Time o		4 140			nce 6 Other (Spe	ecify)	
C C	ding Ph h. After th funeral	on	1 ☑Natural 5 ☐ Pending	(Month,	Day Year)	Injury		njury at Work?		ou. Describe no	w injury occurred		
Sic	tend leath tor: the	cat	2 Accident investigation 3 Suicide 6 Could not be		f terior and t			1 ☐ Yes 2 ☐		04 1			
≥	or All	Certification:	4 Homicide determined	200. Flace 0	, etc. <i>(Special</i>	ome, farm, sti fy)	eet, factory, off	ice	2	City or Town,	eet and Number or P , State)	urai Houte Num	ber,
	urs a												
	Hosp 4 ho Fune Fune	edical	(Check only 2 Medical Exam	iner: On the bas	is of examina	owledge, deat ation and/or in	n occurred at the vestigation, in r	e time, date an ny opinion, dea	id place, a th occurre	nd due to the ca d at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely tilled in by the funeral director.	Med	Une)	and manne	r stated.								
	6 .	-	29b. Signature and title of certifier				290. 00	ense number	0=		d. Date signed (Mon		
•	10		Mycl	MID			LX	1030	73	1	12/31/	00	
			30. Name and address of person who o	completed cause	of death (Iter	m 23a) (Type,	Print)		O E	2	dala m	n 92-	720
			REVA - S. GIL 31. Date filed (Month, Day, Year)	1 6	J/ U	Kunu	1 WORL	n Au	Q P	WOR	1010 1011	J &U,) /
	Sta Registi			006	Journal & Signa	F Ap	SASLI				dolo mi		

Principle (Accided Examine) An resist years of restriction, year series est number) An resist years of restriction, year series est number) An resist years of restriction, year series est number) An resist years of restriction of the series of the se				State Registrar	tate of Ma	ryland / Depa <i>Ce</i>	artment or rtificate		th		g. No.)5 L	365	
Seminor of the control of the contro					ıgh					Month	Day			₹ M
Second December 10 10 10 10 10 10 10 1	100											•		
The property of the property o	. \$		4			(In vrs. last birthday)				8. Date of Birth		9. Birtho	ace (State or	Foreign
The properties of the properti				.14 - 74-0256	0.00		Months [Days Hour	rs Min. Se	(Month, Day, ptember	16, 1	Coun	try)	-
The part of the pa	laryland	ed at	'n	10a. State 10b. County								1		
The part of the pa	th the A	or 28a-f	Direct							10			try?	
The part of the pa	ath w	s 23a	rai		Was Decedest S	iver in LLS 12			Origin? (Spec	cifu Yes or No-			an Indian.	
The process of the pr	J.So urs after de	of, or item	5	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give	0				Rican, etc.)	В	llack, White,	etc.	
The part of the pa	275-00 Ithin 72 hou	an "netur	npieted	(Specify only highest grade of Elementary/Secondary (0-12)	om <i>pleted)</i>	(Give	kind of work DO NOT use	done during n	most of workin	ng			dustry	
Physician Medical Examiner 23a Part Effer the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, infrired Belivees shock, or heart failure. List only one cause on example and the death of the cause of the caus	led will	her th				stude	ent	18. M	other's Name					
Physician Medical Examiner 23a Part Effer the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, infrired Belivees shock, or heart failure. List only one cause on example and the death of the cause of the caus	/lanc	rked of	To Be					Bar	bara B	rooks			-	
Physician Medical Examiner 23a Part Effer the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, infrired Belivees shock, or heart failure. List only one cause on example and the death of the cause of the caus	Mary od 2 sho lith and	27 is marrian												3
Physician Medical Examiner 23a Part Effer the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, infrired Belivees shock, or heart failure. List only one cause on example and the death of the cause of the caus	Ore,	if item or other			oval from State	20b. Place of Disp cemetery, cre	osition (Name ematory or oth	of er place)		006				
Physician Medical Examiner 23a Part Effer the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, infrired Belivees shock, or heart failure. List only one cause on example and the death of the cause of the caus	IItim nit. Pa	ortant: injury								F1			ryland	
Privisician Medical Examinor Part	B	1000		Sharow Can	ille T	line 16	21 Opc	ssumto	wn Pik	e, Fred	erick;			21702
Due to (or as a consedunce of): Comparison Compariso	Phy	/sician		shock, or heart failure. List only one Immediate Cause (Final disease or condition	tions that caused cause on each lin	the death. Do not en	- (Approximate Interval Betw Onset and D	veen)eath
9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1	760, te be executed	sician and surial-translt	cal	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Moto Due to (or as	r Vehicle a consequence of):	e col	lision						
1 Natural and Accident 3 Suicide 4 Homicide 1 Natural and Number of Rural Route Number, Suicide 4 Homicide 1 Natural and Number of Rural Route Number, Suicide 4 Homicide 1 Natural and Number of Rural Route Number, Suicide 4 Homicide 1 Natural and Number of Rural Route Number, Suicide 4 Homicide 1 Natural and Number of Rural Route Number, Suicide 4 Homicide 1 Natural and Number of Rural Route Number, Suicide 4 Homicide 1 Natural and Number of Rural Route Number, Suicide 1 Natural and Number of Rural Route Number, Suicide 1 Natural and Number of Rural Route Number, Suicide 1 Natural and Number of Rural Route Number, Suicide 1 Natural and Number of Rural Route Number, Suicide 1 Natural and Number of Rural Route Number, Suicide 1 Natural and Number of Rural Route Number, Suicide 1 Natural and Number of Rural Route Number, Natural And Number of Rural Route Number	O. Box 68	y the attending pliched for use as t	nysician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death 3					1		-	rear
1 Natural and Accident 3 Suicide 4 Homicide 1 Natural and Number of Rural Route Number, Suicide 4 Homicide 1 Natural and Number of Rural Route Number, Suicide 4 Homicide 1 Natural and Number of Rural Route Number, Suicide 4 Homicide 1 Natural and Number of Rural Route Number, Suicide 4 Homicide 1 Natural and Number of Rural Route Number, Suicide 4 Homicide 1 Natural and Number of Rural Route Number, Suicide 4 Homicide 1 Natural and Number of Rural Route Number, Suicide 1 Natural and Number of Rural Route Number, Suicide 1 Natural and Number of Rural Route Number, Suicide 1 Natural and Number of Rural Route Number, Suicide 1 Natural and Number of Rural Route Number, Suicide 1 Natural and Number of Rural Route Number, Suicide 1 Natural and Number of Rural Route Number, Suicide 1 Natural and Number of Rural Route Number, Natural And Number of Rural Route Number	ds, Puires that	5 8	þ	Part II. Other significant conditions contri	buting to death b	ut not resulting in the	underlying car	use given in P	Part I.					
1 Natural are Accident 3 Suicide 4 Homicide 1 Natural are Accident 3 Suicide 4 Homicide	I Recor	ate has page 2	Complete							autops perfori	med2	prior to co death?	mpletion of ca	available ause of
1 Natural are Accident 3 Suicide 4 Homicide 1 Natural are Accident 3 Suicide 4 Homicide	Vita	certific rector,	Be	examiner?	spital:	-4		T.a.				011 / / / / /		
30. Name and address of perso, a geompleted cause of death (Item 23a) (Type, Print) with shington win y flog reta 217 30. Name and address of perso, a geompleted cause of death (Item 23a) (Type, Print) with shington win y flog reta 217 251 E. Antietam Street Hersetown MD	of g Phys	er this eral di	n: To	27. Manner of Death	28a. Date of Inju	ry 28b. Time		4					y)	
30. Name and address of perso, a geompleted cause of death (Item 23a) (Type, Print) with shington win y flog reta 217 30. Name and address of perso, a geompleted cause of death (Item 23a) (Type, Print) with shington win y flog reta 217 251 E. Antietam Street Hersetown MD	rision Attending	death. ctor: Aft y the fun	ficatio	3 ☐ Suicide 6 ☐ Could not be	Dec 30 28e. Place of Inj	2005 75 ury - At home, farm, s	7 PM	1 🗆 Yes	/ -	28t. Location (Si	reet and No	umber of Rur	al Route Num	iber,
30. Name and address of perso, a geompleted cause of death (Item 23a) (Type, Print) with shington win y flog reta 217 30. Name and address of perso, a geompleted cause of death (Item 23a) (Type, Print) with shington win y flog reta 217 251 E. Antietam Street Hersetown MD	Div.	urs after arei Dire illed in E	Certi	4 Horricide	Street	-	ath ac	t the time of t	to and place	R+ 75,	South	of Un	-	8
30. Name and address of perso, a geompleted cause of death (Item 23a) (Type, Print) with shington win y flog reta 217 30. Name and address of perso, a geompleted cause of death (Item 23a) (Type, Print) with shington win y flog reta 217 251 E. Antietam Street Hersetown MD	HOSE	n 24 ho he Fune oletely fi	edica	(Check only 2 Medical Exemine	r: On the basis of	examination and/or	investigation,	in my opinion,	, death occurr	ed at the time, d	ate and pla	ce, and due t	o the cause(s	;}
22 Depoint to Signature	Tott	To the	Σ	29b. Signature and true of certifier	200	HE KATCH								
20 Date Fled (Africk Co., Voor) 20 Dagistaria Signatura	3			30. Name and address of perso	pleted cause of d	leath (Item 23a) (Type	a, Print) U	Ashing El E	ston w	unt y 405	rital	contr	win Th	21740
State 31. Date filed (Month, Day, Year) 32. Registrar IAN 0.4. 2006	- 5			31. Date filed (Month, Day, Year)	32. Regist	r's Signature	G1_/	I E. A.	116/5 60	en olyc	C Re	7000	4	.,

KOtch

ME Signed #296

			For State Registrar	State of Ma	*	partment of			_	giene		3658
	Physicia /Medic	an	1. Decedent's Name (First, Middle 4 dna H	, Last))			D	2. Date of De Month	ath Day	Year 2005	3. Time of Death 7:35A M
	Examin		4a. Eacility Name (If not institution	n, give street and number) G and Reha	bilitatio	rester		of Death erlin		4c. Coun	ty of Death	ester
	Funeral Director		5. Social Security Number 177-14-5418	6. Sex 1 ☐ M 2 ☐ F	(In yrs. last birtho	Months Da	ear If Unde ays Hours	Min.	8. Date of Bir (Month, Da 12-2-1	th ay, Year) 913	9. Birthpl Count Penns	ace (State or Foreign try) Sylvania
	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County Delaware Suss		10c. City, Town o						10	0d. Inside City Limits
	or 28a	Directo	10e. Street and Number	,ex	Trank	10f. Zip Coo	de			10g. Citizen o	f What Count	try?
	eath w	Funeral	Rt#4 Box 91	12. Was Decedent E	ver in U.S.		9945	rigin? (Spe	cify Ves or No	US	ace - America	an Indian
936	72 hours after death with tha Maryland neturel', or Itams 23a or 28a-f show Jisal Examilter mast be malfilled at	þ	1 ☐ Never Married 2 ☐ Marria 3 ☒ Widowed 4 ☐ Divorced	Armed Forces? ried 1 ☐ Yes 2 ☑ No		I3. Was Decedent If Yes, specify (1 ☐ Yes 2 ☒️			Rican, etc.)	Spec	ack, White, e	
21215-0036	⊆ - 2	Completed		t's Education st grade completed) College (1-4or 5+	(G	ecedent's Usual Oci live kind of work do le. DO NOT use re	ocupation one during mo atired)	st of workir	ng	16b. Kind of	Business/Ind	lustry
	filed with Hygiene. other than		12 17. Father's Name (First, Middle,	Last)		Homemakeı		ner's Name	(First, Middle	Nor , Maiden Surna		
, Edna Maryland	should baind Mental I marked o	To Be	George O. Hud						odfrey			
Re Hary	2 should have ls maintained		19a. Informant's Name/Relations			ailing Address (Sta						
	ges 1 and of 10 tof Health If item 27 or other tr		Lois E. Davis 20a. Method of Disposition	/ Daughter	20b. Place of Di	56 Hards o sposition (Name o	of .		l, Seaf	ord, DE		
_ 0	0 0		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Roxana (crematory or other Cemetery	place)	12-31	- 05	Frankf	ord, I)elaware
Quillen Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of The All Service	Thelson		relson Fu Thatcher						
•	/Medical Examiner	Examiner	23a. Part1 Enter the disease, or shock, or heart failure List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a),	theros						Approximate Interval Between Onset and Death ALA S
P.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death	3 □Ectopic pregn: 5 □ Other (specif)					ate of deliver	ry Day Year
	puires that n signed t	by	Part II. Other significant condition of the condition of	ons contributing to death but	not resulting in th	e underlying cause	given in Part	l.		obacco use co Yes 2□No		e cause of death?
Reco	sicien: The law requir s certificate has been si irector, page 2 should	Completed							24a. Was autop perfo 1 □ Yes		prior to com death?	osy findings available appletion of cause of
/ital	Physicien: The this certificate hiral director, page	Be	25. Was case referred to medica examiner?				0.11		(Check only o	one)		
of	Phy rthis ral d	To To	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatien 28a. Date of Injury (Month, Day	t 2 ER/Outpa		Other: 4 14 Nork?			dence 6 🗆 O)
Division of Vital Records,	or Attending Phy ifter death. Director: After thi in by the funeral.	Certification:	1 🖺 Natural 5 🗌 Pendir 2 🗎 Accident investi 3 🗍 Suicide 6 🗎 Could 4 🗍 Homicide determ	gation not be 200 Place of laws	y - At home, farm	М	1 Yes 2		8f. Location (: City or Tox		nber or Rural	Route Number,
	Hospitel 4 hours 2 Funerel tely filled	Medical Ce	29a. Certifier 1 Certifyir (Check only one) 1 Medicel	ng Physician: To the best of Exeminer: On the basis of and manner state	examination and/o	eath occurred at the rinvestigation, in r	ne time, date a ny opinion, de	nd place, a ath occurre	nd due to the od at the time,	cause(s) and n	nanner as sta , and due to	ated. the cause(s)
	To the within 2 To the complei	Me	29b. Signature and title of certifie		in, N	_	cense number	(DE		29d. Date sign		
2	712		30. Name and address of person	who completed cause de-	ath (Item 23a) (Ty							DE 19944
	Sta Registr	1.00	31. Date filed (Month, Day, Year)		's Signature	Sparke	1-01/7/			- ISUA		מצדרו שני
		11 7	UEU 3	I LUUJI Willes	A F.5"	The state of the s						

DHMH 17 Rev 1/2001

1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** De 31,2005 12:40a Stephen Roscoe /Medical 4a. Facility Name (If not institution, give street and number)
Montgomery General Hospital 4b. City, Town, or Location of Death Olney 4c. County of Death
Montgomery Examiner 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Month, Day Year) 7/28/1911 9. Birthplace (State or Foreign 1**⊠** M 2 □ F 211-03-9511 Director Greene Co.PA 94 Usual Residence of Decedent death with the Maryland or 28a-f show 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Md Howard Glenwood Completed by Funeral Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 21738 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Importent: If them 27 is marked other than "naturat", or itema 23a or any injury or other traumatic event, tra Madical Examinar must be once. 14527 Mac Clintock Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Memorial Monuments 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unknown unknown ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14527 Mac Clintock Dr. Glenwood, Md 21738 George S.Roscoe/Son 20a. Method of Disposition 20b. Place of Disposition (Name of Greenwood of Cernertery 1/4/2006 Wheeling, Wy State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signatura o Funeral Service Licensee PHILIP D. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or healt failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MumoNIA 48 Houry /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I my leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (bries a consequence of) the attending physician and hed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ Be Completed 2 No 1 ☐ Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) this Certification: To 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide tarrelation (Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D2594 96kmpfor 31, 2005 2 30. Name and address of person w ted cause of death (Item 23a) (Type, Print) Evelyn Jackson, 11801 Prince Philip Dr. Olney, Md 20832 MD. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1,24a per doc 9851 1-18-06 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Paul. Eugene Stonebraker 3. Time of Death **Physician** Day Month Stonebraker, Paul /Medical 21 December 2005 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick
If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**X** M 2□ F Months Days Hours Director Yrs. 213-24-6008 December 2,1928 WVUsual Residence of Decedent 10a. State r then "natural", or iteme 23s or 28s-f show the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Lee Fort Myers Direct 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2961 Renee CT 33905 Funeral USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. □XYes 2 □ No Yes, Give 1 Never Married 2 Married 1 Yes No Specify: þ If Yes, Give Year or Dates: 3√ Widowed 4 Divorced Specify: White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinist Ith and Mental Hygier 27 le marked other the r traumatic event, the Truck Manufacture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Leander Stonebraker ဥ Bernice Leone Shrout 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2019 William Franklin Dr. Frederick, MD 21702 Tina Brant/Dauchter other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ŏ permit. Page Department of Important: if eny injury or once. Fairview Christian 12/27/05 Artemas, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 141 West Main Street cost C Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STROKE Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physicien and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4□Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 2 ANo 1 ☐ Yes 1 ☐ Yes 2 ☐ No in by the funeral director. Be 25. Was case referred to medical 26. Place of Death Check only one) examiner? No 1 Tes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide pelli Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the occurse(s) and mainter as stated. 29a, Certifier Medical

certificate be executed 68760 P.O. The law requires that Records, of Vital Division Hospital or Attending death after within 24 hours a To the

hes

this

After

Director:

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. If Item 27 ie merked other then "natural", or iteme 23

21215-0036

Baltimore, Maryland

completely

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print Hemen 31. Date filed (Month, Day, Year) 32. Reg

18

2005

(Check only one)

29b. Signature; and title of certifier

ar's Signature

29c. License number D0060417

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

	1	For State Registrar	St	ate o	f Maryl	•	artment of H			giene 10005	43661
_		Decedent's Name (First, Midd	le, Last)						2. Date of Dea Month		3. Time of Death
Physician	_	Elsie Virgin	ia Sut	thar	d				Decembe	er 29, 2005	1:18 A M
/Medical	_	la. Facility Name (If not institution					4b. City, Town, or	Location of Dea	th	4c. County of Deat	
		Charlestown Nu	rsing 6. Sex	Cen		yrs. last birthday)	Catonsv	rille If Under 24 Hrs		Baltimore 9. Birt	nplace (State or Foreign
Funeral Director	- 1	579-62-9352	1 M	2 X) F	90	Yrs.	Months Days	Hours Min		r, Year) Co	rginia
Mc #	- 1-	Usual Residence of Decedent 10a. State 10b. Count	,		10c	. City, Town or L	ocation				10d. Inside City Limits
ms 23a or 28a-1 show Injust be nutified at	LOIS	MD Baltin	ore Co	٥.		Catonsvi	11e				1 X Yes 2 □ No
r Itams 23a or 28a-1 si	Dire	10e. Street and Number	Т.		#00EC		10f. Zip Code 21228			10g. Citizen of What Co	untry?
ns 23g	e a	709 Maiden Ch:	12. V	Vas Dec	edent Ever		Was Decedent of H	ispanic Origin? (Specify Yes or No-	14. Race - Ame	
Ital Hygiene. Id other than "natural", or Itana 23a or 28a-f show event, Its Medical Examinar must be nutified at event, Its Medical Examinar must be nutified at	by run	1 ☐ Never Married 2 ☐ Ma 3 🖫 Widowed 4 ☐ Divorce	ried 1	med For Yes Yes, Gi	2 XNo		If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	in, Mexican, Pue Specify:	rto Rican, etc.)	Black, Whit	
atura lical E	ered	15. Decede (Specify only high	nt's Educationst grade con			(Give	dent's Usual Occup	during most of wo	orking	16b. Kind of Business	Industry
al Hygiene. Lother than " went, the Mac	Completed	Elementary/Secondary (0-12)			1-4or 5+)	life.	<i>DO NOT</i> use retired nemaker	1)		Home	
other ent, II	Se Co	17. Father's Name (First, Middle	, Last)			1101	KIRCI		ame (First, Middle,	Maiden Sumame)	
atic ev	0	John William	Petty						e P. Whea		
item 27 is markad of other freumatic eve		19a. Informant's Name/Relation				1 2000				r, City or Town, State,	
item 27 l	1	William L. Sur 20a. Method of Disposition		•	20	Ob. Place of Disp			Date	wn Marylan 20c. Location - City or	Town, State
nt: If is		1	3 □Remo Specify)	val from	State	ashingto	on Nat. Ce	em.		Suitland, M	
Department of Important: If i any injury or one once.		21. Signature of Funeral Price	-11/			2	2. Name and Addres	ss of FacilityLe	e Funera	I Home Calv	ert, P.A. , MD 20736
ıysician		23a. Part1. Enter the disease, shock, or heart failure. Lis	or complication	ause on	each line.		iter the mode of dyin		ac or respiratory ar	rest,	Approximate Interval Between Onset and Death
Medical taminer		disease or condition resulting in death)	(a		_	nsequence of):	RMERTI	~			
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹	Due to	(or as a co	nsequence of):					
cia	dical Exal	that initiated events resulting in death) Last	d	Due to	(or as a co	nsequence of):					
- 03	a) +	IF FEMALE:	23c. l	lf ves. a	utcome of pr	regnancy				23d. Date of de	livery
the attending p	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		1 Live	birth 2 🗍	Fetal death 3	□Ectopic pregnancy □ Other (specify) _	/		Month	Day Year
engi be o	þ	Part II. Other significant condi	tions contrib	uting to	death but no	ot resulting in the	underlying cause giv	ren in Part I.		obacco use contribute to	
page 2 should	Completed					_				prior to death?	utopsy findings available completion of cause of
certificate	Be Co	25. Was case referred to medic	al			-		26. Place of D	1 ☐ Yes eath (Check only o		2 110
nis cer direct	To B	examiner? 1 ☐ Yes 2 ☐ NO	Hosp	1 _] Inpatient	2 🗆 ER/Outpatie		4 Hursing		dence 6 Other (Spe	ocify)
After t		Z L Accident	tigation	8a. Date (Mo	of Injury nth, Day Ye	ar) 28b. Time Injury	Wor	yat rk? Yes 2 □ No	28d. Describe I	how injury occurred	
within 24 hours after death To the Funeral Director: completely filled in by the	Certification;	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	d not be mined 2	8e. Plac buil	ce of Injury - ding, etc. (S	At home, farm, s Specify)	treet, factory, office		28f. Location (S City or Tov	Street and Number or R wn, State)	ural Route Number,
within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier 1 Certify (Check only one) 2 Medic	ring Physicia al Examiner:	On the	ne best of m basis of exa nner stated.	amination and/or	ath occurred at the til nvestigation, in my	me, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
within 24 hours a	ž	29b. Signature and title of certif	ier	0			29c. Licens	se number		29d. Date signed (Mon	
		Kleneen	Dow	Ki.	V	U.O	DY 4	1377		12/29/05	
0		30. Name and address of person	n wno comp	FN FN	7-11 M	New Clem	Chaice	Lave	Coton	isville, n	ND 21228
Stat		31. Date filed (Month, Day, Yea	ir)	32.	Registras	Signature	San H.	,	,		
Registra	ar	.14	N - 3	2006	Des	ELARA ST.	Monde	7			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 12 to POT NOTATION 12 TO 1 - For Stata Ragistra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Savage Luther John Month Year **Physician** 03:25 AM TOHN Delenber 2005 29 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Butmore BALTIMORE CITY Hopkins The Johns If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Hours 1 € M 2 □ F NOV 7, 79 MARYLAND 222-12-9293 1926 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 23s or 28a-f show other traumetic event, the Madical Examiner, ust be notified at 1 ☐ Yes 2 No Directo DELAWARE SUSSEX SELBYVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 36325 PEPPER ROAD U.S.A. Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 Is marked other then "natural", or Items 236 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced WHITE Year or Dates: 1944-45 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PUMP ASSEMBLY WORKER MANUFACTURING 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MAUDE McCABE OLLIE SAVAGE, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARIETTA HALL / DAUGHTER 28143 SEAFORD ROAD, LAUREL, DELAWARE 19956 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If any injury or once. REDMENS CEMETERY 1/3/2006 SELBYVILLE, DELAWARE * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility WATSON FUNERAL HOME, INC. 21. Signature of Fyheral Service Licensee Kickend alson 211 WASHINGTON ST., MILLSBORO, DELAWARE 19966 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 15 days **Physician** Intracerebral Hemorrhage disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 307512 Hypertention
Due to (or as a consequence or). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical the use as I Box (IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. the a 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No COPD Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) within 2 To tha 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number RES-600 December 29, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21287 600 N. Wolfe Loenis

Registrar

State

31. Date filed (Month, Day, Year) JAN 0 3

egistrar's Signature

2006

Sharman,

		-	For State Registrar	State	of Marylan		irtment of H tificate of L		-	giene 0	5	43664	
	- 2 % - ₂ .	7	Decedent's Name (First, Middle	e, Last)					2. Date of De	ath		3. Time of Death	
	Physicia		Elizabeth		Stah1				Decemb		Year 005	1014 ^M	
	/Medic Examin		4a. Facility Name (If not institution	n, give street and nu	ımber)		4b. City, Town, or	Location of Death		4c. County of	of Death		
1		200	Anne Arundel	Medical (Center		Annapo	lis		Anne	Aru	ndel	
7	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ay, Year)		place (State or Foreign	
Ne z	Director		142-62-0551	1 □ M 2 💢 F	84	Yrs.			Oct. 1	2, 1921	Hun	gary	
	pu ≱		Usual Residence of Decedent 10a, State 10b, County		10c. Cit	y, Town or Lo	cation				1	Od. Inside City Limits	
	short stands	ក										1 XYes 2 ☐ No	
	the N	ect	NJ Somer	set	птт	1sboro	10f. Zip Code			10g. Citizen of W	hat Cour	ntry?	
	with		40 Woods Road				088	44		USA			
	ns 23	Funeral Director	11. Marital Status	12. Was Dec	cedent Ever in U.	.S. 13. V	Vas Decedent of H	ispanic Origin? (Sp	ecify Yes or No	o- 14. Race	- Americ	can Indian,	
0	riter	Fun	1 Never Married 2 Mar	n, Mexican, Puerto	Rican, etc.)		k, White,						
ဗ္ဗ	al', o	by	3XXWidowed 4 ☐ Divorced	Specify:		Specify:	W.	hite 					
2	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "natural", or items 23s or 28s-f show event, the Medical Examinating input teanoithed at	Completed		nt's Education est grade completed	ation during most of work	ang	16b. Kind of Bu	siness/In	dustry				
2	thin	npie	Elementary/Secondary (0-12)	1)									
2	filed w Hygier Sther th		12	o (Eiret Middle	Own Hot								
<u>n</u>	m = 0 5	Be	17. Father's Name (First, Middle,	Last)					nknown	, maiden damam	*/		
Maryland 21215-0036	2 should be and Mental is marked o	ဥ	Johann Blum 19a. Informant's Name/Relation:	chin (Tyne Print)		19h Mailin	ng Address (Street			per City or Town.	State. Ziu	Code)	
Z Z	d 2 si th an 17 is r		Henry Stahl (S	-			immons La						
ō,	1 an Heal tem 2		20a. Method of Disposition		20b. F	lace of Dispo	sition (Name of natory or other place		Date Par	20c. Location -		own, State	
io E	ages ant of it: if i		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (n State		Mem. Par		30-2005	N. Bruns	swi c	k. N.T	
Baltimore,	ortar		21. Signatu e of Funeral Service		475		. Name and Addre	ss of Facility			J.,	210	
ä	permit. Pages 1 and 2 should by Department of Health and Menta Important: if Item 27 is marked eny injury or other traumatic engo.		10 9.		•			Funeral ly Avenu			0 21	401	
8.55 13.	3.38		23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that	caused the deat	h. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory	arrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Meh	abili.	Ence	sha line	-thy				Onset and Death	
1	/Medical		resulting in death)	Due to	o (or as a conseq	uence of):	2012/10/21						
1	Examiner		Sequentially list conditions,	b. 13p	gration	~ 8	Neunes	MA					
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹	o (or as a conseq	uence oy:							
_	cate be executed physicien and the burial-transit	хап	that initiated events resulting in death) Last	c. Due to	o (or as a conseq	uence of):							
8760,	sicien buris	dicai E											
687	ficate g phy:	0		u									
Вох	death certific e attending p ed for use as i	N N	IF FEMALE: 23b. Was decedent pregnant		outcome of pregna		Ectopic pregnancy	,		23d. Date			
	0 0 0	icia	in the past 12 months2 1 ☐ Yes 2 ☐ No		gnant at time of o		Other (specify)			Mor	ith	Day Year	
P.O	that the de ed by the detached	å.	9 🗆 Unknown						00 Did			the serves of death?	
	Se 69	Completed by Physician/M	Part II. Other significant condit	ions contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I.			3 Pro	the cause of death? bably 4 Unknown	
Records,	w require been si should	ted	Myochmia)	1 rrpnc	1100								
ec	aw Is b	npie	Granic 10	1d ney	diseas	Ė	,		24a. Wa auto	opsy p	Vere auto Prior to co leath?	opsy findings available ompletion of cause of	
E E			Senila Mene	nha of	the	1/2	heimer	s Kypi	1 ☐ Yes	2 □ No 1	Yes	20 No	
Vital	Physician: The I this certificate ha ral director, page	Be	25. Was case referred to medic examiner?	Hospital:		Inno to the	2 DOA Ott	26. Place of Dea			(С	4.)	
ŏ	Phys r this ral di	 7	1 Yes 2 No	28a. Dat	e of Injury	ER/Outpatier 28b. Time o	f 28c. Injur	y at		how injury occurr	· · ·	(y)	
O	th. : Afte	ţi	Natural 5 ☐ Pend	ing (Mo	onth, Day Year)	Injury	Wor	k? Yes 2∐No					
Division of	28a. Date of Injury Specific Part Par									er or Rur	al Route Number,		
Ö	s afte	Cert	4 [] Notificide	Juli	Iding, etc. (Speci	·y/ 			J., J.				
	To the Hospital or Attending Phyminin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical		ing Physician: To to il Examiner: On the and ma									
	To the Within Fo the	Me	29b. Signature and title of certif				29c. Licens	se number		29d. Date signed	1 (Month	Dey, Year)	
			11-0	VS			1000	5763	5	Dec ?	27,	2005	
			30. Name and address of perso			4 1		_		1-		- 11.5	
			1 in Wern.	5 200		0 0 0	Parlewi	y Un	napol	" Mrc	7 2	11701	
· ·	St Regist	ate rar	31. Date filed (Month, Day, Yea	The state of the s	. Pogistrar's Sign	ature	fork						

		1 - State Ragistrar	Frank 1815		,		tificate of	Health and Death	R	eg. No.	Ub	43665		
hysicia /Medic		1. Decedent's Name ROSI	(First, Middle, Las ETTA	STEWA	ART				2. Date of Dea Month DEC.	-	:0ŏ5	3. Time of Death 3:1.8 A		
Examin		4a. Facility Name (If r						or Location of Deat			nty of Death			
			Cross					er Spri				OMERY		
ineral rector		5. Social Security Nur 577-32- Usual Residence of D	3086	9X /. □ M 2 X F	85	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Pay Feb. 3	1920	9. Birth Ma	pplace (State or Forei intry) ryland		
8 ₩			10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limi		
등급	į	MD	Montg	omery		K∈	nsingt	on			ĺ	1 3 Yes 2 □ N		
23s or 28s-f show ust by notified at	by Funeral Director	10e. Street and Numb	oer Plyers 1	Mill Ro	ad		10f. Zip Code	20895	1	0g. Citizen o	of What Cou	untry?		
iteme 2	era	11. Marital Status		12. Was Decede	ent Ever in U	.S. 13. V	Vas Decedent of	Hispanic Origin? (S pan, Mexican, Puer	pecify Yes or No-			ican Indian,		
ু ভা	by Fur	1 ☐ Never Married		Armed Force 1 Yes 2 If Yes, Give Year or Date	∑ No	i	Yes, specify Cub ☐ Yes 2 1 No		o Rican, etc.)	Spec	lack, White cify: B	lack		
In the second	ted	1 (Saacié	5. Decedent's Ed	ucation		16a. Deced	ent's Usual Occu	pation during most of world)	rkina	16b. Kind of	Business/I	ndustry		
importent if them 27 is marked other then "naturel", any injury or other traumatic event, the Mudical Englosse.	Completed	Elementary/Second		College (1-4	or 5+)	life. L	Domes		King	Н	ome			
Vent,	To Be Co	17. Father's Name (F.	irst, Middle, Last)					18. Mother's Nar	me (First, Middle, i	Maiden Sum	ame)			
ntic e		Samuel	Davis					Catl	herine	Kelly				
		19a. Informant's Nam		* :		1.0		and Number or Ru						
שבילים בי		Pamela		ian (Ni		-	-	en St.,	-					
100				Removal from Sta	nte C	emetery, crem	atory or other pla	ice)						
		a é	//		Ash									
any in		21. Signature of Fune	Method of Disposition Querial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1-3-06 Sandy Spring, MD Compatibility of Place of Disposition (Name of cemetery, crematory or other place) 1-3-06 Sandy Spring, MD Compatibility of Place of Disposition (Name of cemetery, crematory or other place) 1-3-06 Sandy Spring, MD Compatibility of Place of Disposition (Name of cemetery, crematory or other place) 1-3-06 Sandy Spring, MD Compatibility of Place of Disposition (Name of cemetery, crematory or other place) 1-3-06 Sandy Spring, MD Compatibility of Place of Disposition (Name of cemetery, crematory or other place) 1-3-06 Sandy Spring, MD Compatibility of Place of Disposition (Name of cemetery, crematory or other place) 1-3-06 Sandy Spring, MD Compatibility of Place of Disposition (Name of cemetery, crematory or other place) 1-3-06 Sandy Spring, MD Compatibility of Place of Disposition (Name of cemetery, crematory or other place) 1-3-06 Sandy Spring, MD Compatibility of Place of Disposition (Name of cemetery, crematory or other place) 1-3-06 Sandy Spring, MD Compatibility of Place of Disposition (Name of cemetery, crematory or other place) 1-3-06 Sandy Spring, MD Compatibility of Place of Disposition (Name of cemetery, crematory or other place) 1-3-06 Sandy Spring, MD Compatibility of Place of Disposition (Name of cemetery, crematory or other place) 1-3-06 Sandy Spring, MD Compatibility of Place of Disposition (Name of cemetery, crematory or other place) 1-3-06 Sandy Spring, MD Compatibility of Place of Disposition (Name of cemetery, crematory or other place) 1-3-06 Sandy Spring, MD Compatibility of Compatibility of Compatibility of Compatibility of Compatibility of Compatibility of Compatibility of Compatibility of Compatibility of Compatibility of Compatibility of Compatibility of Compatibility of Compatibility of Compatibility of Compatibility of Compatibility of Co											
ician dical niner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Causey (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): Coronary Artery Disease										Approximate Interval Between Onset and Death 12 days		
ne burial-transit	icai Examiner	Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):												
ast	Med	IE EEMALE:												
by the ellending physiached for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Fregnant at time of death 5 □ Other (specify)								Date of deliv Month	rery Day Year			
be detac	Ph Ph	Part II. Dther signific	ant conditions co	ontributing to deat	h but not resi	ulting in the un	derlying cause gr	ven in Part I.	23e. Did tot	pacco use co	ntribute to	the cause of death?		
should be	ted b	Cere	brovasc	ular A	ccide	nt			1 🗆 Ye	s 2½ No	3 ☐ Pro	bably 4 Unknow		
Dage 2	Completed								24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No		prior to condeath?	opsy findings availal ompletion of cause o		
rector, pag	Bec	25. Was case referred	-					26. Place of Dea	th (Check only on					
al dire	၉	1 ☐ Yes 2 ☑ No	0			ER/Outpatient	3U DON		ome 5 Reside			fy)		
the funera	Certification:	27. Manner of Death 1 ⊠Natural 2 ☐ Accident	5 Pending investigation	1	28b. Time of Injury	M 1	ryat rk?]Yes 2 ☐No	28d. Describe ho	w injury occ	urred				
þ	Certifi	3 Suicide 4 Homicide	6 Could not be determined	286. Place of	Injury - At ho etc. (Specify	ome, farm, stre	et, factory, office		28f. Location (St City or Town	Location (Street and Number or Rural Route Number, City or Town, State)				
<u> </u>		29a. Certifier 1 (Check only 2 one)	Cartifying Phy	ysician: To the be inar: On the basi and manner	s of examinal	wledge, death tion and/or inv	occurred at the ti estigation, in my	me, date and place opinion, death occu	, and due to the carred at the time, da	ause(s) and rate and place	manner as s	stated. to the cause(s)		
oletely filled in	pa						20 1			01.0.1.				
completely filled in by the funeral director,	Medicai	29b. Signature and tit	le of certifier				29c. Licens	se number	2			Day, Year)		
completely filled in	Medi	29b. Signature and tit	le of certifier	67				50 number	2	12/Z				

DHMH 17 Rev 1/2001

State Registrar Michael Lincoln, M.D.

31. Date filed (Month, Day, Year)

JAN 0 3 2006

3. Registrar's Signature

State of Maryland / Department of Health and Mental Hygienen

			1 - For State Registrar	State o	f Marylar			t of Healti e of Dea		lental Hyg	giene	5	436	67
			1. Decedent's Name (First, Middle	, Last)	7.7.8					2. Date of Dea	ath Day	Vans	3. Time	of Death
	Physici /Medi		DOROT	uv 1	<i>I</i> .	тном	AS			Decembe		Year 2005	1:52	PM
	Examir		4a. Facility Name (If not institution			111011		Town, or Locati	on of Death	, <u>D</u>	4c. County		12.50	
			Tawes Nursing H	OMA				Crisfie	ald.			Som	erset	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year If Un	der 24 Hrs.	8. Date of Birt	h Vear)			or Foreign
	Director		215-20-0714	1 □ M 2 💢 F	9	7 Yrs.	Months	Days Hou	rs Min.	(Month, Da eptember	21,1908		1and	
	p .		Usual Residence of Decedent											
	urylar show	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside	
	Sa-f s	cto	Maryland So	merset				Crisf	ield				ХХ	s 2 No
	iff the	Director	10e. Street and Number				10f. Zip	Code			10g. Citizen of	What Cou	ntry?	
	23e	a	112 Somers Cov	e Apartme	nts			21817	7		1	USA		
	sme.	Funeral	11. Marital Status	12. Was Dece Armed Fo	dent Ever in U rces?	.S. 13.	Was Deced	dent of Hispanic cify Cuban, Mex	Origin? (Sp	ecify Yes or No- Rican, etc.)	14. Plac	ce - Americk, White,	can Indian, etc.	
36	or it	Y FL	1 Never Married 2 Marri	If Yes, Giv	'e		1 □ Yes					y. Whi		
Ö	n 72 hours after death with the Marylan "natural", or items 23e or 28e-f show office! Execultiet is ust be invitted at	d by	3 X Widowed 4 □ Divorced	Year or Da	ates:									
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show then "neturel" or items 21e in villed at	Completed	15, Decedent (Specify only highes	's Education it grade completed)		16a. Dece	tent's Usua kind of wo	al Occupation rk done during rise retired)	nost of work	ing	16b. Kind of B	usiness/In	dustry	
12	withir ane. than	E D	Elementary/Secondary (0-12)	College (1	-4or 5+)						0	Home		
	filed Hygie Ither		17 Father's Name (First Middle)	7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden									2	
anc	ntal land	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surman											
Maryland	2 should be filed within and Mental Hygiene. is markad other than aumatic event, ILAM.	10	Albert Carey Althea Belle Tawes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co.										Codel	-
Ma	d 2 s h an 7 is r traur						ō .			risfiel				,
	of Health of Health item 27 i		Brenda Evans (20a. Method of Disposition	Daughter)	20b. F	Place of Dispo			-	Date	20c. Location			
ō	Pages nent of t ant: If its		1XXBurial 2 ☐ Cremation		State	cemetery, crei	natory or o	ther place)]	1				_
Baltimore,			* 4 □Donation 5 □ Other (Sp		Sun					29, 2005	Crisfie.	ld, M	laryla	nd
Sal	permit. Departr Importa		21. Signature of Funeral Service I	DICILS QUI	DOINT LONG TEXTS TOUT					neral Ho	nme			
	0.07 6 0			adshaw-Pr) 3	06 W.	Main S	treet	- Crisfield, MD 21817				
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	aused the deat	th. Do not ent	er the mod	of dying, such			Approximate Interval Between Onset and Death			
	Physician	П	Immediate Cause (Final disease or condition	End	Stag	re al	Czhi	ines	Se	mente	4		6 6	Le-1
	/Medical Examiner		resulting in death)	Due to (or as a cons	uence of):	0						/	
	LAGITITICI		Sequentially list conditions.	b										
	sit sit	Iner	Sequentially list conditions, if any, isating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.											
	ficate be exacuted physician and s the burial-transit	Examin	that initiated events resulting in death) Last	c										
30,	oe ex	Û.	rooming in doubly east	Due to (or as a conseq	(uence or):								
8760,	ate b hysic the b	dlcal	d											
9	death certifica attending phatfor use as the	Med	IF FEMALE:											
Вох	oth ce	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, out 1□Live b	come of pregna irth 2 🗌 Feta		Ectopic pr	egnancy				te of delive	ery Day	Year
	ne dea the at hed fo	SICI	1 ☐ Yes 2 No	4☐Pregn 9☐ Unkno	ant at time of d	death 5□	Other (sp	ecify)	-		NAIC	// IU /	Day	1 641
P.0	es that the deigned by the	Physician/Me	9 Unknown		4.4.4.4	No. 1				00: Did.				
s,	The law requires that the death certifi site has been signed by the attending page 2 should be detached for use as	by	Part II. Other significant condition	ers contributing to de	ath but not res	1 1	nderlying c	ause given in Pa	art I.		bacco use cont			
Record	w requir been si should	Completed	mean cure	mornia	Durge	DON	e Vi	rexer	1222	, 1 Y	es 2 X No	3 [] Prot	ably 4	JUNKHOWN
ecc	e faw r has be ge 2 sh	ple	Certeriorel	erofie	ard	coras	each	an Le		24a. Was autop			psy finding: mpletion of	
		Ю	Essatial	Herper	fensi	m				perfor	med?	death? 1 🗌 Yes		
Vital	Physician: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?					26. PI	ace of Deat	h (Check only o				
}	ys Si	2	1 Yes 2 No	Hospital: 1 □ I	npatient 2	ER/Outpatien	t 3□ DC	Other: 4	Nursing Ho	me 5 Resid	ence 6 🗆 Oth	er (Specif	y)	
n of	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of	of Injury h, Day Year)	28b. Time of Injury	2	8c. Injury at Work?		28d. Describe h	ow injury occur	red		
Division	or Attending ifter death. Director: After in by the fune	atle	2 Accident investig	jation			М	1 Tes 2	! □ No					
<u> </u>	I or Attendi after death. Director: A I in by the fu	tific	3 Suicide 6 Could r	ined 286. Place	of Injury - At h	ome, farm, str	eet, factory	, office		28f. Location (S	treet and Numb	er or Rura	l Route Nu	mber,
ā	talon rsaft al Di ed in	Certification;	building, etc. (Specify) City or Town, State)											
	To the Hospital within 24 hours a To the Funeral I completely filled		29a. Certifier 1 Certifyin	g Physician: To the	best of my kno	owledge, death	occurred	at the time, date	and place,	and due to the	ause(s) and ma	inner as s	ated.	(-)
	he H in 24 he Fi plete	edic	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										(s)	
							29d. Date signe	d (Month,	Day, Year)					
Tempus Mr. Sellow Mrs. D29505							12-2	7-2	005					
		1	30. Name and address of person	who completed caus	e of death (Iter	n 23a) (Type,	Print)							
			GREGORIO M. 1	BELLOSO	M.D.;	5302	CHIN	ABERRY	DR.	SALISBI	CRY, M	02	1801	
		ate	31. Date filed (Month, Day, Year)	32. R	egistra/s Signa	ature								
	Regist	rar	חדר	2 0 2005	Ma	10	A	. 1.						

			1 - For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of F			ene () (5 43	66	8
			1. Decedent's Name (First, Middle, Last)					Date of Death Month	Day	3. T Year	Time of D)eath
	Physici /Medio		WILLIAM	EARL	TARR	, JR.		Decembe:		2005 7:	:05	AM
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County	of Death		
в			l Village Drive -	Apartment	2	C	risfield		So	merset		
	Funeral		Social Security Number 6. Security Number		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthplace (Country)	State or i	Foreign
	Director		219 – 62 – 9360]M 2□F	50 Yrs.	2,0		January 29	1955	Virgini	.a	
	P ,		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	antion				10d In	side City	Limits
	aryla shov	-	•		Too. City, Town of Ec						ÖKYes 2	
	8e-1	octo	Maryland Somers	et			isfield		- 02	15-14-03-14-0		
	hours after death with the Maryland tural', or Items 23a or 28e-f show at Exeminar must be multified at	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	mat Country?		
	ath v		<u>l Village Drive -</u>		- 2		21817	N-		JSA - American Inc	dia a	
	or Items	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		f Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black	k, White, etc.	aları,	
36	s aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∐ Yes 2 X No If Yes, Give Year or Dates:	,	1 ☐ Yes 2 ☐ Xwo	Specify:		Specify:	White		
21215-0036	u within 72 hours after death with the Marylar plan. I then "natural", or Items 23a or 28e-f show tribe Medical Examinat must be multipal at the Medical Examinat must be multipal at	ed t	15. Decedent's Edu		16a, Dece	dent's Usual Occup	pation	1 1	6b. Kind of Bu	siness/Industry		
5	in 72	Completed	(Specify only highest grad	e completed)	(Give	kind of work done DO NOT use retire	during most of work	ing		,		
72	within iene. then "	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Carpen	ter		Carpe	ntry		
	를 찾 을 부	BeC	17. Father's Name (First, Middle, Last)			Carpen	18. Mother's Nam	e (First, Middle, M			-	
an	0 5 0	To B	William Earl Tar	r			Alice M	aude Map	0			
Maryland	2 should and Men Is marke eumatic	-	19a. Informant's Name/Relationship (T)		19b. Mailie	ng Address (Street	and Number or Run			State, Zip Code)	
			Troy Tarr (Son)		323	l Slim C	hance Lan	e - Sali	sbury,	Marylar	nd 2.1	1804
ē,	os 1 and 2 of Health item 27 l		20a. Method of Disposition	_	20b. Place of Dispo cemetery, crei					City or Town, S		
E	Pages ment of It ant: If its ury or o		1 ☐ Burial 2X Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Salisbury		I I	9/05	Salisbu	ıry, Mar	~vlar	nd
Baltimore,	コモモラ .		21. Signature of Funeral Service Licens	ee , 1 5			Sons Fu			il j i ridi	120.	
ã	permi Depa tmpo any ir		1 ayrock by	sayau +	M L II		in Street			larvlanć	218	817
			23a. Part1. Enter the disease, or comp	ications that caused t	he death. Do not ent					Appr	oximate val Betwe	
			shock, or heart failure. List only o Immediate Cause (Final		A	0 = 2 0	DISEAS	<i>_</i>		Onse	et and De	eath
	Physician /Medical		disease or condition resulting in death)		consequence of):	RTERY	カリンドサマ	6		_		
	Examiner											
	- 25-10	ē	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a	consequence of):							
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	o								
ó	be executed sician and burial-transit	EX	resulting in death) Last		consequence of):							
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cal		d								222.
68	tifica ng ph as th	ed	In France	_ 0								
XO	eath certific attending p	an/N	23b. was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		Ectopic pregnanc	v		23d. Date Mor	e of delivery nth Day	Ve	ear
В.	e dea he att	sici	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at t 9☐Unknown	ime of death 5	Other (specify)			IVIO	illi Day	10	, a
P.0	at the de t by the a stached t	Physician/M	9 Unknown					oos Didash		ribute to the cau	on of do	ath?
Ś	es tha igned be det	by	Part II. Other significant conditions co	ntributing to death but	t not resulting in the u	nderlying cause giv	ven in Part I.			3 🎦 Probably	4 ∐Ur	
ecords,	w requir been si should	Completed						1 10	s 2∐No	7 F TODADIY	4 001	IKIOWI
ecc	e law r has be je 2 sh	ple						24a. Was ar autopsy	p	Vere autopsy fir prior to completi	ndings av	variable use of
		No.						perform 1 ☐ Yes 2		death?	No	
Vital	iffi or,	Be (25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one)			
of V	Physicie this cert al direct	2	1 ☐ Yes 2 No	Hospital: 1 🗆 Inpatien		IL 3L DOA	ner: 4 🗌 Nursing Ho		nce 6 Othe			
		en:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Wo		28d. Describe ho	w injury occurre	ed		
Sio	Attending r death. sctor: After by the fune	catl	Accident investigation]Yes 2□No					
Division	or Attence ifter death Sirector: in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injurbuilding, etc.	ry - At home, farm, st . <i>(Specify)</i>	reet, factory, office		28f. Location (Str City or Town		ar or Rural Rou	te Numb	er,
0	urs af											
	Hospitel 14 hours 2 Funeral 1 tely filled	edical	(Check only 2 Medical Exam	sician: To the best of iner: On the basis of	examination and/or in						cause(s)	
	To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Med	one)	and manner stat		29c. Licens	se number	20	d Date signed	d (Month, Day,	Year)	
	Vitl To	-	29b. Signature and title of certifier	()			88 NUMBER 8	28		iber 29,		25
			Sam		- 0				Decelli	INCT 731	2.00	J.J
			30. Name and address of person who c				_ Dogomol-	o City	Marral	J 230E1		
			Sharad Satyal, 31. Date filed (Month, Day, Year)		oU4 Market r's Signature	. prreer	- FOCOIIIOK	e city, i	narytan	u 21001	-	
	St Regist	ate rar	DEC 3 0	. 61		Popular						

DHMH 17 Rev 1/2001

		•		artment of Health and Me	1	ene 05 4	3669			
	Dhusisi		Decedent's Name (First, Middle, Last)	2	. Date of Death Month	Day Year	3. Time of Death			
	Physicia /Medic		CHARLES THOMAS TAYLOR	D	ECEMBER 28		2:00 A M			
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death				
			900 MILESTONE DRIVE	SILVER SPRING	5 . (5:4	MONTGOMERY				
	Funeral		5. Social Security Number 6. Sex 1 [XM 2 □ F] 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min. 1	Date of Birth (Month, Day, Y 0/30/1937	(ear) 9. Birthpl Coun ILLING	ace (State or Foreign try)			
	Director		352-26-8842 68 11s. Usuel Residence of Decedent		0/30/193/	TELIN	719			
	fand ow		10a. State 10b. County 10c. City, Town or L	ocation		10	Od. Inside City Limits			
	Mary	ţō	MARYLAND MONTGOMERY SILVER SPRIN	IG			1 ∐Yes 2 🖾 No			
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Coun	try?			
	h witi 23a o	a D	900 MILESTONE DRIVE	20904		U.S.A.				
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13.	Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri	fy Yes or No-	14. Race - America Black, White, e				
٥	or ite	F.	1 ☐ Never Married 2 Й Married 1 ☐ Yes 2 🕅 No	1 ☐ Yes 2 ☐ No Specify:	,	Specify: BLA				
ğ	hours after death with the Maryland Lural', or thems 23a or 28a-f show at Exact must be notified at	d by	3 Widowed 4 Divorced Year or Dates:			DLA				
<u>.</u>	"nat	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	, 16	b. Kind of Business/Inc	lustry			
2	withir ane. than	d L	Elementary/Secondary (0-12) College (1-4or 5+) 5+ ATTORI		LAW					
2 2	Hygir ther ant.		17. Father's Name (First, Middle, Last)	First, Middle, Ma						
Maryland 21215-003	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene is and Mental Hygiene is marked other than "natural", or thems 23a or 28a-f show aumatic event, the Medical Esanti har must be notified at	To Be	GLOSTER TAYLOR	N WHITE						
ary	shound M	-		Route Number, C	er, City or Town, State, Zip Code)					
2	1 and 2 Health a tem 27 is		SELMA D. TAYLOR/WIFE 900 M	LESTONE DRIVE, SIVER SP	RING, MAR	YLAND 20904				
altimore,	of Her		20a. Method of Disposition 20b. Place of Disposition cemetery, cre	osition (Name of Date matory or other place)	te 20	c. Location - City or To	wn, State			
Ĕ	Pages nent of h		1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) GATE OF HEA	AVEN CEMETERY 01/06/2	006 SI	LVER SPRING,	MARYLAND			
ə	permit. Pages 1 and 2 should I Department of Health and Men Important: if Item 27 is marke any injury or other traumatic ones.			2. Name and Address of Facility	m TNO					
m	82259		CIMUNUAL PRICEWILL	INES-RINALDI FUNERAL HOM 1800 NEW HAMPSHIRE AVEN	HE. STLVEI	R SPRING, MARY	TLAND 20904			
			23a. Part 1. Enter the disease, or complications that cause the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or i	respiratory arres	t,	Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition	magglive Hea	I Fail	Leve	Onset and Death			
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				<u></u>			
ч	LAGIIIIICI	_	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):	Level tail	ure		140			
	pe pst	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1 2 100			300140			
	and al-trar	xan	that initiated events resulting in death) Last C. Due to (or as a consequence of):	me ta une	/		Travers			
8760	cate be executed physicien and the burial-transit	dical E								
687	ficate physics the	edic	Q							
Box	eath certific ettending p	NA.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	ry			
ă	death s ette d for	Iclai	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (s <i>pecify</i>)		Month	Day Year			
0	that the de led by the e detached f	hys	9 Unknown							
رة.	The law requires that the death certific ate has been signed by the ettending p page 2 should be detached for use as	Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to th				
ä	en sig	ed	1)=abotos 250,62		1 🗌 Yes	2 No 3 Prob	ably 4 Onknown			
၁၁	law re as be 2 sh	pie	Hypertensin youg		24a. Was an autopsy	24b. Were autoprior to con	osy findings available inpletion of cause of			
Ž	The ate his page	E O	Alloga Lini Clonia 272.4		performe	d? death? S No 1 ☐ Yes				
ita	sian: ertific ctor,	Be (25. Was case referred to medical examiner?	26. Place of Death (Check only one)					
Ž	Physician: r this certifica ral director, p	2	1 ☐ Yes 2 🖾 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			ce 6 □Other (Specify	')			
Ē		on:	27. Mann 1 Death 28a. Date of Injury (Month, Day Year) 1 atural 5 Pending (Month, Day Year) 1 Injury	Work?	ld. Describe how	injury occurred				
Sio	death ctor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	of Location (Stre	et and Number or Rura	I Poute Number			
Division of Vital Records,	i or Attendated after death	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, s	treet, ractory, office	City or Town,		n noute Number,			
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune		29a. Certifier 1 X Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, an	id due to the cau	se(s) and manner as st	ated.			
	24 hg Eun etely	edical	(Check only 2 Medical Exeminer: On the basis of examination and/or in one)							
	vithin fo the	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, i	Day, Year)			
	1/		INAK U	014454	1	exam Land	8 05			
	4		30. Name and address of person, the completed cause of death (Item 23a) (Type	, Print)	10	- Collona 1 -	100			
	*		CHARLES FRANKLIN, M.D., 11120 NEW HAMPSHIRE AV	VENUE, SILVER SPRING, MA	RYLAND 209	904				
			31. Date filed (Month, Day, Year) 32 degistrar's Signature	nerte						
	Regist	DEC O O COCE A RECORD								

State of Maryland / Department of Health and Mental Hygiene 05 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 11:29 PM HOAI TRAN December 25 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Takoma Park Washington Adventist Hospital Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1⊠M 2□F Director 65 Vietnam 213.47.6492 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State ral, or Iteme 23a or 28a-f ehow Examiner must be notified at 1 √Yes 2 No Director Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 9807 Arbor Hill Drive 20903 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. If item 27 Is marked other than "natural", or Itel any injury of other treumatic event, the Medical Examinations in injury of other treumatic event, the Medical Examinations 1 ∐Yes 2 ⊠ No If Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Asian 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Food Server Healthcare Services 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Can Van Tran Vau Bau ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Vu Minh Tran/Son-in-Law 8905 Tonbridge Terrace, Hyattsville, Maryland 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Ceme. 12/31/2005 Silver Spring, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licerse HINES-RINALDI FUNERAL HOME, INC. 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Lause (Final disease or condition resulting in death) ANCLONT-C Pnysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine certificate be executed burial-transit and Due to (or as a consequence of): Box 68760 physician ician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year ō in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. the Physir detached 9 Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Ď 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 1 ☐ Yes 2 ☐ No 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA 2 2 ER/Outpatient 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide To the Hospitel within 24 hours a To the Funerel I Hospitel 29a. Certifier l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MA57614 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Don Michael Coleman, II, 1300 Piccard Drive, Suite #202, Rockville, Maryland 20850 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JAN 0 3 2006

State of Maryland / Department of Health and Mental Hygiene () 5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Docember 30, 2005 Elizabeth C. Van Culin 100 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sun If Under 24 Hrs. Deer Ridge Manor Rising Cecil 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2X F Director 148-07-9567 92 03/06/1913 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai, or itema 23a or 28a-f ahov Examiner must be nytified at 1 Yes 2 No Director MD Galena Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11831 Big Stone Road 21635 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after cannot of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural; or item and or other traumatic event, the Medical Expansion any or other traumatic event, the Medical Expansion any Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: White 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Coles Ethel Schidner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ronald Van Culin/Son 34263 Maryland Line RD Galena, MD 21635 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Asbury Cemetery 01/04/2006 Millington MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 370 W. Cypress St Millington, MD 21651 kunt ellans 23a. Parl . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiomy of thy disease or condition resulting in death) 15 chemic 12a15 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infriedrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (u. as a consequence of) Physician/Medical Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 2 **(**No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ۵ 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide within 24 hours a
To the Funeral I
completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death incurred at the time, date and place and due to the cause(s) and malmer as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and fitte of certifier 29c. License number 29d. Date signed (Month, Day, Year) necember 70, 2005 HENry Farkes, MD completed cause of death (Item 23a) (Type, Print) E1kton, 17 D 249 1165 31. Date filed (Month, Day, Year) 32. Regist State 4 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 43672 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death December 23, 2005 **Physician** Woodruff 9:15 A. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Genesis Nursing & Rehabilitation Spa-Creek Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 464-78-4795 Director Massachusetts Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23s or 28s-f ehow 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic avent, the Modical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Sarasota Florida Nokomis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4004 Casey Key Road 34275 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2, No f Yes, Give X 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Semi-Conductors Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roscoe B. Woodruff Elizabeth Dunstan ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H. Wilson (husband) 4004 Casey Key Road Nokomis, Florida 34275 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot December 27, Metropolitan Crematory 2005 Alexandria, Virginia 22. Name and Address of Facility Advent Funeral & Cremation Services 21. Signature of Funeral Service Licensee M00982 42 Hudson St. Suite 110 Annapolis, MD. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GM **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of) Box 68760, Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. à 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 Yes Division of Vital 2 or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1946 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 1 Matural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sutcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of Certifier 29c. License number 29d. Date signed (Month, Day, Year) 133036 Drive Chily MD 216 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 111 31. Date filed (Month, Day, Y State Registrar

DHMH 17 Rev 1/2001

			1 - For Stete Registrar	ate of Maryl		artment of rtificate of		nd Mental Hy	giene)5	43673		
¢	Physici /Medic		1. Decedent's Name (First, Middle, Last) GLADYS ESTELLE DYER	WARREN				2. Date of D. DECEME	ER 29, 2	2 Ŏ Ö5	3. Time of Death 4:41 A M		
	Examin		4a. Facility Name (If not institution, give street SOUTHERN MARYLAND HO	SPITAL CE		4b. City, Town,	ON				ORGES		
基	Funeral Director		5. Social Security Number 6. Sex 1 M Usual Residence of Decedent		yrs. last birthday) Yrs.	If Under 1 Year Months Days		Min (Month D	14, 1922		otace (State or Foreign offy) YLAND		
	ne Maryland 8a-f show	ector	10a. State 10b. County MARYLAND PRINCE GEOR		ORT WASH	INGTON					Od. Inside City Limits XXYes 2 ☐ No		
	23a or 2	Funeral Director	101.06 ALLENTOWN ROAD			10f. Zip Code 2074	4		10g. Citizen of V		*		
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Items 23s or 28s-f show item 27 is marked other than "natural", or Items 23s or 28s-f show other treumatic event, the Medical Examinational be notified at	by	1 Never Married 2 Married 1	Vas Decedent Ever in the variation of t	1	Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 No		in? (Specify Yes or N Puerto Rican, etc.)	Specify	ck, White,			
7	ed within 72 h giene. er then "netu i, the Medica	Completed	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12) 12TH GRADE	npleted)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most (ad)	of working	16b. Kind of B		·		
Maryland 21	should be filed nd Mental Hygi s marked other umatic event, I	To Be (EDWARD DYER WILHELMINA DYER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
Baltimore, Mary	permit. Pages 1 and 2 she Department of Health and Important: If item 27 is ma any injury or other treum: <u>once.</u>		12TH GRADE HOME MAKER HOME MAKIN 17. Father's Name (First, Middle, Last) EDWARD DYER 18. Mother's Name (First, Middle, Maiden Sumame) WILHELMINA DYER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip or Town, St										
8760,	taw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	p	um	-vn-	~	Approximate Interval Between Onset and Death					
O. Box 6	that the death certific ed by the attending pi detached for use as t	Physician/Medical	in the past 12 months?	yes, outcome of pre □Live birth 2 □ F □ Pregnant at time	etal death 3	Ectopic pregnand Other (specify)	ey		23d. D <i>a</i> i Mo	ory Day Year			
Records, P.	w requires that the state of th	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								3 Prob	ne cause of death? ably 4 Unknown psy findings available		
	The ate h page	Completed	Employetts; vin 25. Was dase referred to medical	trul he	ina,	, Deverte	missen	Calen 1 Yes	psy ormed?	prior to cor death?	mptetion of cause of		
Division of Vital	ding Ph	ation: To Be	examiner? 1 Yes 2 No Hospit 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	har	Place of Death (Check only one) United States Place of Death (Check only one) Residence 6 Other (Specify) 28d. Describe how injury occurred 2 No			()					
Divis	ospitel or Attend hours after death unerel Director: ly filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28		28f. Location (City or To	Street and Numb wn, State)	er or Rura	l Route Number,					
	I 4 F 0	edical	29a Certifier (Check only one) Certifying Physician 2 Medical Examiner: (2	n. To the bast of my On the basis of examand manner stated.	knowledga, beat nination and/or in	vestigation, in my	line, date and opinion, death	place, and due to the occurred at the time,	causa(s) and ma date and place,	and due to	thed. the cause(s)		
ı	To the within 2 To the complet	Σ	29b. Signature and title of certifier	Kell An	mo	29c. Licen	se number	376	29d. Date signer	2 9,	Day, Year)		
1)	∩P 3 Sta Registr		30. Name and address of person who comple PANL E. POITCHETT, 31. Date filed (Month, JAN) 3 200	32. Resistrar's Si	(Item 23a) (Type, 2.0, Any l ignature	Print) 317, 11	S LAG	pauge A	V. LAPL	ATA,	2005 MD 20646		

Division of Vital Records, P.O. Box 68/60,	ž	Baltimore, Maryland 21215-0036
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician /Medical Examiner	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23s or 28s-f ehow eny injury or other traumatic event, the Medical Examination to confined at QDCs.

		For State Registrar		State of	of Man	yland /		rtment o <i>tificate</i> d				1ental H	ygie: Reg.	201	05	43675
Physicia	n	1. Decedent's Name (First, Mi John M. Wyma			_							2. Date of D Month Decem		Day O	2 ^V 005	3. Time of Death 6:55 p M
/Medica		4a. Facility Name (If not institu		treet and nu	ımber)			4b. City, Tow	m, or L	.ocation	of Death	becen			y of Death	_
		Holy Cross H	ospit	al				Silv		-					Mon	tgomery
Funeral Director		5. Social Security Number 578–22–2418		M 2□F	7. Age (i	ln yrs. last 82	birthday) Yrs.	If Under 1 Y	ear ays	If Under Hours	Min.	8. Date of E (Month, I July 1	Day, Ye	ar) 1923		place (State or Foreign intry) tucky
M =		Usual Residence of Decedent 10a. State 10b. Cou			1	Oc. City, To	own or Lo	ation								10d. Inside City Limits
T T T	į	Maryland Mo	ntgom	ery		Sil	lver	Spring								1 ☐ Yes 2 ☐XNo
Sa or 28	al Directo	10e. Street and Number 3146 Gracefie	ld Rá	, Fox	Run	Apt.4	120	10f. Zip Coo		904			10g.	Citizen of	What Cou USA	untry?
Exam	by Funeral	11. Marital Status 1 Never Married 2 Nover 3 Widowed 4 Divord	Married	12. Was Dec Armed F 1 1 Yes If Yes, G Year or I	orces? 2∐No ive K∩			Vas Decedent Yes, specify (☐ Yes 2				ecify Yes or N Rican, etc.)	No-	Bla	ce - Amer ack, White fy: Whi	
ne. then "natur se Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Physician 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Physician Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)											ndustry			
Hygie ont, it		College (1-40r3+) 5+ Physician Medical 17. Father's Name (First, Middle, Last) John M. Wyman Lula C. Kain														
Aental rked c	To Be	John M. Wyma	n							Lu	la C	. Kain	1			
alth and A 27 is ma	John M. Wyman 19a. Informant's Name/Relationship (Type, Print) Marie A. Wyman/ Wife 18. Mother's Name (First, Middle, Maiden Sumame) Lula C. Kain 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie A. Wyman/ Wife 18. Mother's Name (First, Middle, Maiden Sumame) Lula C. Kain 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie A. Wyman/ Wife												_{p Code)} MD 2090 ilver Spring			
nent of He ent: if item ary or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Crematic 4 ☐ Donation 5 ☐ Other		emoval from	f	ceme	tery, cren	sition (Name of latory or other an Cremat	place)		Janua 20	one 1,			-	own, State Virginia
Departr Import eny inju		21. Signature of Funeral Serv	ice Licenso	L Co	le		Fr 50	Name and Adancis O Univ	ddress J. ers	of Facili Coll ity	ins Blvd	Funera	l H	ome I	Inc	, MD 20901
nysician Medical		23a. Part1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death)	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Pneumonia Pneumonia													
in and ial-transit	lical Examiner	resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):														
ending r use es	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Part II Other significant conditions contributing to death but not resulting in the underlying over given in Part II 23c. If yes, outcome of pregnancy 1 Diversity 1 Other (specify) 23d. Date of Month 2 Part II Other significant conditions contributing to death but not resulting in the underlying over given in Part II 23c. If yes, outcome of pregnancy 2 23d. Date of Month 2 Pregnant at time of death but not resulting in the underlying over given in Part II 23c. If yes, outcome of pregnancy 2 23d. Date of Month 2 Pregnant at time of death 3 Ectopic pregnancy 3 23d. Date of Month 2 Pregnant at time of death 3 Ectopic pregnancy 3 23d. Date of Month 2 23d. Date of Month 3										very Day Year					
n signed b	2	Part II. Other significant cond Renal Failure							e given	in Part	l.					the cause of death?
ate has bee page 2 sho	Complet	Renal Failure, Coronary Artery Disease 1 Yes 2 No 3 Probably 24a. Was an autopsy performed? death?										opsy findings available ompletion of cause of				
ector,	Re	25. Was case referred to med examiner?	-								of Deat	h <i>(Check onl</i>)				
h. After this c funeral dir	tion: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Per	nding	28a. Date			Outpatien Time of Injury	28c.	Other:	at		ome 5 Re 28d. Describ				ify)
s efter dea el Director ed in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 6 Homicide 6 Homicide 6 Could not be building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)									ral Route Number,					
n 24 hour he Funer pletely fill	edical	29a. Certifier (Check only one) Certi	fying Phys	ner: On the b	e best of r pasis of ex oner stated	camination	ige, death and/or inv	occurred at the estigation, in r	ne time my opir	, date ar	nd place, ath occur	and due to the	e, date	e(s) and m and place,	anner as	stated. to the cause(s)
2+1	Ž	29b. Signature and title of cer	tifier	1				29c. Lic D	240	_			1	_		. Day, Year) O, 2005
		30. Name and address of pers						Print) Road,	Si	lver	Spr	ing, M	1D 2	0904		
State Registra		31. Date filed (Month, Day, Ye JAN	ar) 0 3 2	32.	gistrar's	Signature	A	artis								

				For State Registrar	State of Marylan		nent of Health			ene 200	5 !	3676
	311.78	Physici /Medic		1. Decedent's Name (First, Middle, Las	t)	L	NHITE	SR.	2. Date of Death Month	299	Year	3. Time of Death
		Examin		4a. Facility Name (If not institution, give	1	/ 4b	. City, Town, or Location	of Death		4c. County	of Death	
			果	MINSUL ROGIONAL 5. Social Security Number 6. Se	injection Com	full last histoday) If	Under 1 Year If Under	er 24 Hrs. 8	B. Date of Birth	NIC	MICO	on (Class or Fourier
		Funeral Director			7. Age (In yrs.)		onths Days Hours		(Month, Day,	(ear) 19	Count	ace (State or Foreign ry)
				Usual Residence of Decedent	80				7/		V // ·	
		show	'n	10a. State 10b. County	10c. City	, Town or Location	on //				10	ld. Inside City Limits 1 ☐ Yes 2 No
		28a-1	Director	10e. Street and Number	nacle in	Appsvil	Of. Zip Code		100	g. Citizen of V	What Count	
		3a or	io	111381 NAPh-	ind LN		236	107	1	loite	51	z tes
		after death with the Maryla or Items 23a or 28a-f shov	Funerai	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was	Decedent of Hispanic O s, specify Cuban, Mexica	rigin? (Speci an, Puerto Ri	ify Yes or No-		e - America ck, White, e	n Indian,
	36	s after	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1		Yes 2 No Specify			Specify	01	12
	21215-0036	filed within 72 hours after death with the Maryland Hygiene. wher then "natural", or items 23a or 28a-f show ont, the Mardicul Exam at must be notified.		15. Decedent's Ed	ucation	16a. Decedent	s Usual Occupation		16	Sb. Kind of B	usiness/Indi	ustry
	215	be filed within 72 h Ital Hygiene. Id other then "natu event, tra Mudicul	Completed	(Specify only highest gra	College (1-4or 5+)	life. DO	of work done during mo	ost of working	7	0	1	
		e filed within I Hygiene. other then		17. Father's Name (First, Middle, Last)		IYU	9	har's Name (First, Middle, Ma	TO Suman	& U &	
19,-	Maryland	d la b	To Be	ALEXO I LA	il ites			-	. ?)	10)	
1	ary	2 should be and Mental is marked c	۲	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing A	ddress (Street and Numi	ber or Rural F		City or Town,	State, Zip (Code)
J		D = 6 =		HANNAh whi	te (WiFe)	14381	NAPhan	iel 4	Nm	APPSV	ille	1423407
٦.	Baltimore	permit. Pages 1 an Department of Heal Important: if item 2 eny injury or other once.		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	lace of Dispositio emetery, cremato	ry or other place)	Dat	19 20	oc. Location -	City or Tov	vn, State
لع	를	permit. Pages Department of Important: If if eny injury or c		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		0 1 1 1 1 1 1	me and Address of Faci	1-1-	ARTON	PUSV	CONFT.	Jone
Elane	Ba	permit. Departn Imports eny injk		Edge Kil	whatton	22	171 WhA	eten 1	Rd A	Come	oc V	423361
\mathcal{Z}		4		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the death	n. Do not enter th	e mode of dying, such a	as cardiac or r	respiratory arres	t,		Approximate Interval Between
4	k.	Physician		Immediate Cause (Final disease or condition resulting in death)		coccus	aurens	50	psis			Onset and Death 3 day 5
		/Medical Examiner			Due to (or as a conseq	uence of):						
		D ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Unidonying Cause (Disease or injury	Due to (or as a conseq	uence of):						
		and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence	uence of):						
	8760,	e be e. rsician e buria	icai E	l	d							
	.89	rtificat ng phy as the		IEEE WALE	The state of the s							
	Box 6	ath cer ttendir or use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	Ideath 3 □Ect	opic pregnancy				te of deliver	y Day Year
	P.O. I	the dec	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	eath 5□Oth	ner (specify)					104
		s that in the part of the part	by Ph	Part II. Other significant conditions	ontributing to death but not res	ulting in the under	lying cause given in Part	t I.	23e. Did toba	cco use cont	ribute to the	cause of death?
	ords	equire en sig ould b		chronic renal-	Failure				1 🗆 Yes	2 🗆 No	3 🗌 Proba	bly 4 Unknown
	Seco	e 2 sh	Completed	coronary arter	y direate				24a. Was an autopsy	24b.	Were autop	sy findings available pletion of cause of
	alF	n: The ficate r. pag		multiple inje	ma					₹No	death? 1 🗆 Yes 2	2□ No
	<u> </u>	s certi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ER/Outpatient 3	Othor		<i>Check only one,</i> e 5 ☐ Residen		er (Specific)	1
	اه د	ng Ph) ter thi neral c		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		d. Describe how			
	sio	tendir leath. tor: Al	catic	2 Accident 5 Pending investigation 3 Suicide 6 Could not be			M 1 Yes 2					
	Division of Vital Records,	al or At efter of Direct d in by	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, y)	factory, office	28	f. Location (Stre City or Town,	reet and Number or Rural Route Number, , State)		
		To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death. To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai C	29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death oci tion and/or invest	curred at the time, date a gation, in my opinion, de	and place, an eath occurred	ise(s) and ma e and place,	anner as sta and due to	ited. the cause(s)	
D30853						29d. Date signed (Month, Day, Year)						
						D3082	3		12/2	-9/05		
	_			30. Name and address of person who Charles B. S	completed cause of death (Item	1 23a) (Type, Prin	insula Region	nal M	edical (enter	Sali	shory mes
		Sta Regist		31. Date filed (Month, Day, Year) JAN 0 3 2	32. Registrar's Signa	ture				_		,
	DH	IMH 17 Rev 1/2	tight t		J. R. R. L.	KI. KIDA	4					

ORIGINAL

			For State Registrar	State of Ma	ıryland		artment of I tificate of		nd Me		iene	5	3677
	Physicia /Medic	an	1. Decedent's Name (First, Middle Jeffrey	J.	7	Yarem	ıko		2	Date of Deat Month Dec. 2	Day	Year 05	3. Time of Death 8:38a
	Examin	er	4a. Facility Name (If not institution, Shady Grove	Adventist				ville			Мо	nty of Death	-
já	Funeral Director		5. Social Security Number 158-52-3387 Usual Residence of Decedent	6. Sex 7. Age	50	st birthday) Yrs.	If Under 1 Year Months Days		Min.	Date of Birth (Month, Day, 9 / 26 / 1	Year) 1955	9. Birthp Cour New	lace (State or Foreign htry) Jersey
	Maryland a-f ehow		10a. State 10b. County MD Montgo	omery		Town or Lo Germa	cation ntown					1	0d. Inside City Limits 1 ☐ Yes 2 🔯 No
	th with the 23s or 28s	Funeral Director	10e. Street and Number 13145 Dairy I	Maid Drive			10f. Zip Code 2087	4		1	-	What Cour	itry?
980	9 within 72 hours after death with the Maryland plene. I then naturel, or items 23s or 28s-(show the Madical Examiner must be maillied a	by	11. Marital Status 1 ☑ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? ed 1 Yes 2 N If Yes, Give Year or Dates:	Ever in U.S.		Was Decedent of f Yes, specify Cub		in? (Specif Puerto Ric	iy Yes or No- can, etc.)	В	lace - Americ lack, White, cify: Wh	
Maryland 21215-0036	d within piene. r then "	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Peter Yaremko 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) Truck Drives 18									Business/Ind	dustry
yland	ould be filed Mental Hygid arked other atic event, II	To Be (First, Middle, I Smytan			
, Mar	and 2 sho ealth and m 27 le mu		19a. Informant's Name/Relations Peter Yaremko			7 E	ast 35		reet	New Y	ork,	New Y	ork
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important; if tem 27 is marked any niury or other traumatic appage.		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)	pecify)	ASS	metery, crer Sumpt	sition (Name of natory or other pla Lion Cet		Dat 03/20	006	Wood		e,N.J.
Ball	Departition Depart		21. Signature Funeral Service	Coulds							lver	ERVIC Spri	E, P.A. ng, Md2091
8760,	Physician /Medical Examiner	il Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditione, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	only one cause on each lin	NTP/ a conseque LM % a conseque	ence of):	OR, EN						Interval Between Onset and Death £MM1230
P.O. Box 687	The law requires that the death certificate be executed tab as been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal o	death 3[Ectopic pregnani Other (specify)	су				Date of delive	∋ry Day Year
	quires that n signed b ıld be deta	þ	Part II. Other significant condition	- 100			nderlying cause g	_	_		bacco use co		he cause of death? pably 4 (Wonknown
Vital Records,		Completed								24a. Was a autops perform	SV	b. Were auto prior to co death? 1 \(\sum \text{Yes}	psy findings available mpletion of cause of 2 No
Division of Vita	or Attending Physician: The fler death. Sirector: After this certificate h in by the funeral director, page	Certification: To Be	25. Was case referred to medical examiner? 1	ry y Year)		f 28c. Inju	ther: 4 Nur ury at ork? Yes 2 N	rsing Home 28		ence 6 00000000000000000000000000000000000	curred	(y) al Route Number,	
	29a. Certifier 1 Certifying Physician: To the best of my k						(Specify) If my knowledge, death occurred at the time, date and place, an examination and/or investigation, in my opinion, death occurred				City or Town, State) tice, and due to the cause(s) and manner as stated. ccurred at the time, date and place, and due to the cause		
20019								39		_	ned (Month,	Day, Year) 2 8 2 20 5	
7 19	St Regist	ate rar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Differ and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) JAN 0 3 2006 32. Fegistrar's Signature										

State of Maryland / Department of Health and Mental Hygiphe () 5 1 - For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death December 30,2005 **Physician** Rose Yee 12:20 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien of Mt. Airy Mt. Airy Carrol1 Months Days Hours Min. B. Date of Birth (Month, Day, Year)

July 30,1916 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕇 F Months 89 Yrs. California 578-50-9742 Director Usuel Residence of Decedent the Maryland 10c, City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show may injury or other traumatic event, the Medical Exacultant cust be notified at once. 10a. State 10b. County 1 ☐ Yes 2 No Directo Frederick Maryland Mt. Airy 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 13473 Four Seasons Court 21771 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Asian Specify: Completed by 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jen Chin Gee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alyssa Smith/Granddaughter 13473 Four Seasons Court, MT. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 01/04/2006 Brentwood, MD Fort Lincoln Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Stauffer Funeral Home, Pa 8 E. Ridgeville Blvd, Mr. Airy, MD 21771 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Intensons morths Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 4☐ Pregnant at time of death 5 Other (specify) P.O. be detached 9 Unknown cate has been signed by page 2 should be detacl Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 Yes 2 4 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1 Yes 2 No Hospital or Attending Physicisn: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No this Director: After the 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No s after death investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical To the within 2. and manner stated. 29b. Signature and file of conflier 29c. License number 29d. Date signed (Month, Dey, Year) 1-3-06 026499 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Culwell Drive Mt. Airy, Maryland Ronald E. Miller, M.D. 2006 Shaw & Species State Registrar

		1 - For State Registrar	State of Ma	ryland / Dep	artment		and Menta h	l Hygie,	gen 0.5	43679
Phys:	iciar dica		Szaja Z	ONSZAJN			Dec.	of Death	2005 Yee	3. Time of Death 3:15 A M
Exan		As Estimated the second to the		hington	1	own, or Location ckville	n of Death		4c. County of De Montge	
Funer Directo		5. Social Security Number 6. S 219-96-7817		(In yrs. last birthday 94 Yrs.) If Under 1 Months	Year If Und Days Hours	er 24 Hrs. 8. Date Min. June	e of Birth nth, Day, Ye 21,	1911 P	Birthplace (State or Foreign Country) Tand
anyland show	Τ,	Usual Residence of Decedent 10a. State 10b. County Maryland Montgon	nerv	10c. City, Town or L						10d. Inside City Limits 1 □ Yes 2 □ No
vith the M r or 28a-f be notified	Directo	10e. Street and Number 17 Candlelight Co			10f. Zip C	^{20de} 2085	54	109.	Citizen of What nited S	
portition of the proof of the p	yotoal Oleanin		12. Was Decedent E Armed Forces? 1 Yes 2 N II Yes, Give Year or Dates:	o 13.	Was Decede If Yes, specif		Origin? (Specify Yean, Puerto Rican, e	s or No- etc.)	14. Race - Al Black, W Specify:	merican Indian, hite, etc. White
d within 72 hor giene. er than "natura".	Completed by	15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12) 12	ducation ide completed) College (1-4or 5-	(Giv	edent's Usual e kind of work DO NOT use	done during m	ost of working	16b	Clothin	•
uld be file Mental Hy Irked othe	Tobo	17. Father's Name (First, Middle, Last,				Sara	ther's Name (First, th Weinbe	rg		
and 2 sho saith and in 27 is my er traumy		19a. Informant's Name/Relationship (Sabina Dym, Daug	**				aber or Rural Route art, Potoi			
Dallillore, Dermit. Pages 1 a Department of Hee mportant: If item	B	20a. Method of Disposition 1 W Burial 2 Cremation 3 C 4 Donation 5 Other (Specif		20b. Place of Disp cemetery, cri	osition (Name ematory or oth non Cen	e of er place) letery (Date 01/02/06	7	Location - City	
permit. Departr Importa	OUC9.	21. Signature of Fyrieral Service Licer	nsee				ew Fune			20012
Physicia	an	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each lin	the death. Do not ere.	nter the mode	of dying, such a	as cardiac or respir	atory arrest,		Approximate Interval Between Onset and Death
/Medica	er	resulting in death)	b. Much to (or as a	consequence of):						2uks
OX 00/00, certificate be executed ding physician and use as the burial-transit	Tool Evaning	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last	c	a consequence of):						
death death e atter d	Lolo, cololox	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death 3	□Ectopic pred □ Other (spec				23d. Date of o	delivery Day Year
quires that n signed that	2		-	_		-				to the cause of death? Probably 4 Munknown
The lay ate has page 2	opolomo	arting disease	D hyper te	nsian O	Darkin	Son's d		a. Was an autopsy performed	prior t death	
this pla	j.	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manns of Death 1 Yeatural 5 Pending	Hospital: 1 Inpatie			da-		Residence	e 6 □Other (S	pacify)
al or Attending F s after death. Il Director: After id in by the funera		2 Accident investigation 3 Suicide 6 Could of the det investigation 4 Homicide		ry - At home, farm, s . (Specify)	treet, factory,		28f. Loc	ation (Stree or Town, S	t and Number or tate)	Rural Route Number,
To the Hospital or within 24 hours after To the Funeral Discompletely filled in	17	29a. Certifier 1 Certifying P!	nysician: To the best of miner: On the basis of and manner sta	examination and/or i	ith occurred at nvestigation, i	t the time, date n my opinion, d	and place, and due eath occurred at th	to the cause e time, date	e(s) and manner and place, and o	as stated. lue to the cause(s)
To th within To th	100	29b. Signature and title of certifier Muconn	2.5.6	FLOO, MO		License numbe D 61934			Date signed (Mo	
V		30. Name and address of person who Z.S. Geloo, M.D.	completed cause of de	eath (Item 23a) (Type	reet,	Baltimo	ore, MD	22125		
	State istra	31. Date filed (Month, Day, Year) DEC 3 0 3	32. Registra	r's Signature	perk					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Rebecca OGZI A M oroth +dams DECEMBER 29 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DRCHESTER CAMBRIDGE GENERAL DORCHESTER HUSPITAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 216-38-8603 Director 6 Feb. 28,1941 Marylano Usual Residence of Decedent permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if tiem 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examples. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 PYes 2 □ No Director MDDorchester ast New Market 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 420 Road 31 USA SSICK 2/6 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: δ Specify. Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State Hospital Aide Nurses-100 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) EMORY Strawberry 19a. Informant's Name/Rela onship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cbde) Cambridge Bettway Cambridge, MD, 2/6/3 Lolita Ferguson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 5 106 Thompsontown, MD. * 4 ☐ Donation 5 ☐ Other (Specify) Thompson to wn Cemetery 22. Name and Address of Facility Home, P.A. 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Lypanco HOUS Due to (or as a const uence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine consequence of Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 Who
9 Unknown Year Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 the citi 0 AC 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 25 Hospital: 1 Inpatient 2 Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 3□ DOA 28b. Time of 27. Manger of 28c. injury at Work? 28d. Describe how injury occurred Naturai

/Medical Examiner The law requires that the death certificate be executed physician and s the burial-transit Division of Vital Records, P.O. Box 68760 use as signed by the attending I be detached for use as has certificate To the Hospital or Attending Physician: this After thi hours after death. within 24 hours after deat. To the Funeral Director: filled in by

Certification:

2 Accident

3 🖺 Suicide

29a. Certifier

4 Homicide

Medical

State

Registrar

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) the chifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) of certifier 29b. Signatur. 10

29c. License numbe

29d. Date signed (Monty, Day, Year)

me and a completed cause of death (Item 23a) (Type, Print) NARR! D.0 Lo 100 Bramble

2006³². Registrar's Signature 31. Date filed (Month, Day, Yea 0

		-	for Amend I	State of Marylantems 23a, Pt, II	,1,25,2 Ce	7, 28a-f per rtificate of De	r ME, G851	01/187	Obdhb)	43681
			Decedent's Name (First, Middle, I				2.	Date of Death		3. Time of Death
Total a	Physicia /Medic Examin	al -	DOROTHY NORAL 4a. Facility Name (If not institution, g			4b. City, Town, or Lo		NOVEMBE	R 4, 2005 4c. County of Deet	11:15 P M
	LAdilliii	C1	REEDERS MEMORIAI	HOME.		BOON	NSBORO		WASHIN	IGTON
	Funeral			. Sex 7. Age (In yrs	. last birthday)	If Under 1 Year If	f Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Y	9. Birth	nplace (State or Foreign untry)
	Director		216-38-0524	1□ M 2 X F 80	Yrs.		0	CT. 14,		ENGLAND
	and w	}	Usual Residence of Decedent 10a. State 10b. County	10c. C	city, Town or Lo	ocation				10d. Inside City Limits
	Aaryla r eho	5		TOTON		D()	ONSBORO			1 ☐ Yes 2 🔯 No
	28a-	Director	MARYLAND WASHIN 10e. Street and Number	NGTOIN		10f. Zip Code	JNSDURU	10g	. Citizen of What Co	untry?
	72 hours after death with the Maryland Instural', or Itams 23a or 28a-f ehow deat Exac it at mant be neitified at	<u> </u>	20810 MOUSETOWN	ROAD		217	713		U.S.	Δ
	death ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,		Yes or No-	14. Race - Ame	rican Indian,
9	after or Ita		1 Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give	1		mexican, Puerto Pica Specify:	an, etc.)	Black, White	e, etc.
93	ral',	d by	3 Widowed 4 Divorced	Year or Dates:		10 163 200 160	Specify.		Specify: W	HITE
21215-0036	72 h "natu	Completed	15. Decedent's (Specify only highest)	Education grade completed)	(Give	dent's Usual Occupation kind of work done duri	on ing most of working	16	b. Kind of Business/	Industry
121	within iene. than "	du	Elementary/Secondary (0-12)	College (1-4or 5+)	ilre.	DO NOT use retired)	FCC		TOTTITATO A	1ANUFACTURE
	filed Hygi ther int,		17. Father's Name (First, Middle, La	<u> </u> st)		SEAMSTRI	ப்பப் 8. Mother's Name <i>(F</i> .			MINUFACTURE
Maryland	Mental Mental arkad o	To Be	ERNEST F. THACKI	ER		1	LILLIAN W.	COX		
J.	should be and Menta is marked sumatic ev	-	19a. Informant's Name/Relationship		19b. Maili	ng Address (Street and			City or Town, State, 2	(ip Code)
			ROY L. BOOTH/SPO	OUSE	2081	O MOUSETOWN	N ROAD, BO	ONSBOR), MARYLAN	D 21713
Baltimore,	es 1 and of Health fitam 27 r other tr		20a. Method of Disposition	20b.	Place of Dispo cemetery, cre	osition (Name of matory or other place)	Date	20	c. Location - City or	Town, State
E			1 ■ Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spe		SE HILI	L CEMETERY	11/09/	2005 HA	GERSTOWN,	MARYLAND
alti	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Li			2. Name and Address	of Facility 76		national	
<u>m</u>	Dep Imp		Tave 1/1/A	Paul m. D		AST FUNERAL	BC		, Marylan	
п			23a. Part . Enter the disease, or shock, or heart failure. List or	omplications that caused the deanly one cause on each line.	ath. Do not en	ter the mode of dying,	such as cardiac or re	espiratory arrest	,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	1 1	_		-	-		Ottoor and boath
4				a. Acert	e M.	10 candra				i dig
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):	Typertensiy	e Atheros	cleroti	ic TOBSO	1 hr
	/Medical Examiner	Je	resulting in death)	b. Ath	rescl	Typertensiy		cleroti	lc sease	tears.
	Examiner	mlner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Due to (or as a conse	rescl	Typertensiy	e Atheros	cleroti	ic sease	they Years.
,	Examiner	Examiner		b. Ath	equence of):	Typertensiy	ve Atheros	cleroti	sease	tears.
760,	Examiner cian and burial-transit	cal Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a conse	equence of):	Typertensiy	ve Athéros ardiovascu	cleroti	sease	1 hr Years
68760,	Examiner Asician and be burial-transit	ical	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse	equence of):	Typertensiy	ve Atheros	cleroti	ical examiner	ters.
68	Examiner Asician and be burial-transit	ical	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	b. Due to (or as a consect. Due to (or as a consect.) Due to (or as a consect.) Due to (or as a consect.)	equence of):	Hypertensiv	ve Athéros ardiovascu	cleroti	CAL EXAMINER 23d. Date of del	
. Box 68	Examiner Asician and be burial-transit	ical	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths? 1 Yes 2 No	b. Due to (or as a consect. Due to (or as a consect.	equence of): equence of): equence of):	Typertensiy	ve Athéros ardiovascu	cleroti	ICAL EXAMINER	Years.
. Box 68	Examiner Asician and be burial-transit	ical	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 gnonths? 1 Yes 2 No 9 Unknown	b. Due to (or as a consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consec	equence of): equence of): equence of): equence of): equence of): equence of): equence of):	Ectopic pregnancy	ve Atheros ardiovascu	Cleroti Dar Dis	ICAL EXAMINER 23d. Date of del Month	Day Year
P.O. Box 68	Examiner Asician and be burial-transit	ical	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	b. Due to (or as a consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consec	equence of): equence of): equence of): equence of): equence of): equence of): equence of):	Ectopic pregnancy	ve Atheros ardiovascu	CLEROTIS DAT DIS NOVED BY MED	CAL EXAMINER 23d. Date of dei Month cco use contribute to	Day Year the cause of death?
P.O. Box 68	Examiner Asician and be burial-transit	ical	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 gnonths? 1 Yes 2 No 9 Unknown	b. Due to (or as a consect. C. Due to (or as a consect. d. 23c. If yes, outcome of pregnent at time of 90 Unknown.	equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of):	Ectopic pregnancy Other (specify)	re Atheros ardiovascu CERTIFICATION APP	DAT DIS	CAL EXAMINER 23d. Date of del Month cco use contribute to	Day Year the cause of death? obably 4 □Unknown
P.O. Box 68	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	ical	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 gnonths? 1 Yes 2 No 9 Unknown	b. Due to (or as a consect. C. Due to (or as a consect. d. 23c. If yes, outcome of pregnent at time of 90 Unknown.	equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of):	Ectopic pregnancy	re Atheros ardiovascu CERTIFICATION APP	23e. Did toba	CAL EXAMINER 23d. Date of del Month cco use contribute to	Day Year the cause of death? obably 4 □Unknown
Records, P.O. Box 68	The law requires that the death certificate be executed that the attending physician and page 2 should be detached for use as the burial-transit in the control of the cont	Completed by Physician/Medical	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 MNo 9 Unknown Part II. Other significant condition	b. Due to (or as a consect. C. Due to (or as a consect. d. 23c. If yes, outcome of pregnent at time of 90 Unknown.	equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of): equence of):	Ectopic pregnancy Other (specify) underlying cause given	ve Atheros ardiovascu CERTIFICATION APP in Part I.	23e. Did toba 1 Yes 24a. Was an autopsy 1 Yes 2 Yes	CAL EXAMINER 23d. Date of del Month cco use contribute to	the cause of death? obably 4 Unknown stopsy findings available completion of cause of
Records, P.O. Box 68	The law requires that the death certificate be executed that the attending physician and page 2 should be detached for use as the burial-transit in the control of the cont	Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 gnonths? 1	b. Due to (or as a consect of the control of the co	equence of): eq	Ectopic pregnancy Other (specify) Remote hea	The Atheros ardiovascus ardiov	23e. Did toba 1 Yes 24a. Was an autopsy performs 1 Yes 25check only one)	23d. Date of del Month 23d. Date of del Month 22 No 3 pr 24b. Were au prior to death? 1 yes	o the cause of death? obably 4 Unknown utopsy findings available completion of cause of
of Vital Records, P.O. Box 68	Physician: The law requires that the death certificate be executed the continuous contin	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths? 1	b. Due to (or as a consect. C. Due to (or as a consect. d. 23c. If yes, outcome of preganant at time of 9 Unknown 15 contributing to death but not reconstributing .	equence of): eq	Ectopic pregnancy Other (specify) Remote hea	in Part I. 26. Place of Death (C. Nursing Home	23e. Did toba 1 Yes 24a. Was an autopsy performe 1 Yes 2	23d. Date of del Month 23d. No 3 Pr 24b. Were au prior to death?	o the cause of death? obably 4 Unknown utopsy findings available completion of cause of
of Vital Records, P.O. Box 68	ng Physician: The law requires that the death certificate be executed that this certificate has been signed by the attending physician and meral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death No 27. Manner of Death No 27. Manner of Death Pending	b. Due to (or as a consect. C. Due to (or as a consect. d. 23c. If yes, outcome of pregnant at time of 9 Unknown as contributing to death but not reconstributing to death but not reconstribution. Sei Hospital: 1 Inpatient 2 28a. Date of Injury Month, Day Yeer)	equence of): eq	Ectopic pregnancy Other (specify) Landerlying cause given Cant 3 DOA Other of 28c. Injury a Work?	in Part I. 26. Place of Death (Control of Death	23e. Did toba 1 Yes 24a. Was an autopsy performe 1 Yes 2	23d. Date of del Month 23d. Date of del Month 22 No 3 Pr 24b. Were au prior to death? No 1 Yes	o the cause of death? obably 4 Unknown utopsy findings available completion of cause of
of Vital Records, P.O. Box 68	ng Physician: The law requires that the death certificate be executed that this certificate has been signed by the attending physician and meral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths? 1	b. Due to (or as a consect. C. Due to (or as a consect. d. 23c. If yes, outcome of pregative birth 2 Fe 4 Pregnant at time of 9 Unknown as contributing to death but not reconstructions to death but not reconstruction. Sei Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Yeer) 12/13/2004	equence of): eq	DECtopic pregnancy Other (specify) underlying cause given Remote head ant 3 DOA Other. of 28c. Injury a Work? OWN/ 1 Ye	The Part I. CERTIFICATION APPLICATION APP	23e. Did toba 1 Yes 24a. Was an autopsy performs 1 Yes 2 Check only one) 5 Residen 1. Describe how abject 1.	23d. Date of dei Month 23d. Date of dei Month 22 No 3 Pr 24b. Were au prior to death? 1 Yes 26 Other (Specinjury occurred	Day Year the cause of death? obably 4 Unknown itopsy findings available completion of cause of 2 No
Records, P.O. Box 68	ng Physician: The law requires that the death certificate be executed that this certificate has been signed by the attending physician and meral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 gnonths? 1	b. Due to (or as a consect. C. Due to (or as a consect. Due to (or a	equence of): eq	DECtopic pregnancy Other (specify) underlying cause given Remote head ant 3 DOA Other. of 28c. Injury a Work? OWN/ 1 Ye	The Part I. See Place of Death (Control Nursing Home It 280 Is 2 Mark No. 281 281 281 281 281 281 281 281 281 281	23e. Did toba 1 Yes 24a. Was an autopsy 1 Yes 25check only one) 5 Residen 1. Describe how 25check of Street 26check of S	23d. Date of del Month 23d. Date of del Month 22 No 3 Pr 24b. Were au prior to death? 1 No 1 Yes 24c 6 Other (Special Injury occurred) 24c and Number or Russiale)	Day Year the cause of death? obably 4 Unknown itopsy findings available completion of cause of 2 No
of Vital Records, P.O. Box 68	ng Physician: The law requires that the death certificate be executed that this certificate has been signed by the attending physician and meral director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Investigation investigation 28. Certifier Certifying 29a. Certifier Certifying	Due to (or as a consect. Due to (or as a consect.) Due to (or as a consec	equence of): eq	Ectopic pregnancy Other (specify) underlying cause given Remote head ant 3 DOA Other. of 28c. Injury a Work? Own 1 Ye treet, lactory, office	in Part I. 26. Place of Death (Company) Nursing Home It 28c Is 2 X No SU Adde and place, and Idade an	23e. Did toba 1 Yes 24a. Was an autopsy 1 Yes 25check only one) 5 Residen 1. Describe how 25check only one 26check only one 36check only one 3	23d. Date of del Month 23d. Date of del Month 22 No 3 Pr 24b. Were au prior to death? 1 No 1 Yes 24b. Were au prior to death? 1 Yes 25d. No 1 Road, Bose(s) and manner as	Day Year of the cause of death? obably 4 Unknown ottopsy findings available completion of cause of 2 No cify) ural Route Number, oonsboro, MD
of Vital Records, P.O. Box 68	ng Physician: The law requires that the death certificate be executed that this certificate has been signed by the attending physician and meral director, page 2 should be detached for use as the burial-transit	edical Certification; To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 gnorths? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Investigation b. Due to (or as a consect. C. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Pregnant at time of 9 Unknown Dunknown Dunknown Sei Hospital: Inpatient 2 28a. Date of Injury 28a. Date of	equence of): eq	DEctopic pregnancy Other (specify) underlying cause given Remote head and 3 DOA Other. of 28c. Injury a Work? Own 1 Ye treet, lactory, office th occurred at the time, nvestigation, in my opin	in Part I. 26. Place of Death (Company) 27. Nursing Home 28. Survey 28. Mac. 28. Mac. date and place, and inn, death occurred	23e. Did toba 1 Yes 24a. Was an autopsy performs 1 Yes 2heck only one) 5 Resident 1. Describe how abject of the cau at the time, date	23d. Date of del Month 23d. Date of del Month 24b. Were au prior to death? No 1 Yes 24b. Were au prior to death? 1 Yes 24c. Were au prior to death? 1 Yes 24d. Were au prior to death? 1 Yes 24d. Were au prior to death? 1 Yes 24d. Were au prior to death? 1 No 1 Yes 24d. Were au prior to death? 24d. Were au prior to death? 24d. Were au prior to to death? 24d. Were au prior to death? 24d. Were au prior to death? 24d. Were au prior to death? 24d. Were au prior to death? 24d. Were au prior to death? 24d	the cause of death? obably 4 Unknown stopsy findings available completion of cause of 2 No cify) ural Route Number, consboro, MD stated. o to the cause(s)	
of Vital Records, P.O. Box 68	ng Physician: The law requires that the death certificate be executed that this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 gnonths? 1	Due to (or as a consect of the conse	equence of): eq	DEctopic pregnancy Other (specify) underlying cause given Remote head ant 3 DOA Other. Year 28c. Injury a Work? Own 1 Ye treet, lactory, office th occurred at the time, nivestigation, in my opin 29c. License r	in Part I. 26. Place of Death (Company) 27. Nursing Home 28. Survey 28. Machine, date and place, and individual courred number	23e. Did toba 1 Yes 24a. Was an autopsy performe 1 Yes 25heck only one) 5 Residen 1. Describe how abject d Location (Stre City or Town, ousetown at the time, date	23d. Date of del Month 23d. Date of del Month 24b. Were au prior to death? No 1 Yes 24b. Were and Prior to death? 1 Yes 24b. Were and Prior to death? 1 Yes 24b. Were and Prior to death? 25d. No 3 Prior to death? 1 No 1 Yes 24b. Were and Prior to death? 25d. No 3 Prior to	the cause of death? obably 4 Unknown stopsy findings available completion of cause of 2 No cify) ural Route Number, consboro, MD stated, to to the cause(s) h. Dey, Year)
of Vital Records, P.O. Box 68	ng Physician: The law requires that the death certificate be executed that this certificate has been signed by the attending physician and meral director, page 2 should be detached for use as the burial-transit	edical Certification; To Be Completed by Physician/Medical	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 gnonths? 1	b. Due to (or as a consect of the property of	equence of): eq	Ectopic pregnancy Other (specify) Underlying cause given Cant	in Part I. 26. Place of Death (Company) 27. Nursing Home 28. Survey 28. Machine, date and place, and individual courred number	23e. Did toba 1 Yes 24a. Was an autopsy performe 1 Yes 25heck only one) 5 Residen 1. Describe how abject d Location (Stre City or Town, ousetown at the time, date	23d. Date of del Month 23d. Date of del Month 24b. Were au prior to death? No 1 Yes 24b. Were au prior to death? 1 Yes 24c. Were au prior to death? 1 Yes 24d. Were au prior to death? 1 Yes 24d. Were au prior to death? 1 Yes 24d. Were au prior to death? 1 No 1 Yes 24d. Were au prior to death? 24d. Were au prior to death? 24d. Were au prior to to death? 24d. Were au prior to death? 24d. Were au prior to death? 24d. Were au prior to death? 24d. Were au prior to death? 24d. Were au prior to death? 24d	the cause of death? obably 4 Unknown stopsy findings available completion of cause of 2 No cify) ural Route Number, consboro, MD stated, to to the cause(s) h. Dey, Year)
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Certification; To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	b. Due to (or as a consect. C. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Pregnant at time of sect. Sei Hospital: 1 Inpatient 2 Author Sei Place of Injury - At building, etc. (Special Sect. (Special Sect.) 2 Physicien: To the best of my k exeminer: On the basis of examinand manner stated.	paquence of): paquen	Ectopic pregnancy Other (specify) Underlying cause given Canal in Part I. 26. Place of Death (Company) 27. Nursing Home 28. 2 X No St. 28. date and place, and inion, death occurred number	23e. Did toba 1 Yes 24a. Was an autopsy performe 1 Yes 2 Check only one) 5 Residen 1. Describe how abject 1 Location (Stree City or Town, ousetown 1 due to the cau at the time, dat	23d. Date of dei Month 23d. Date of dei Month 22 No 3 Pr 24b. Were au prior to death? 1 Ves 26 Other (Specinjury occurred Eell et and Number or Rustate) 1 Road, Bo se(s) and manner as e and place, and due 3. Date signed (Month) D Vewbey	othe cause of death? obably 4 Unknown stopsy findings available completion of cause of 2 No cify) ural Route Number, consboro, MD is stated. o to the cause(s) h. Dey, Year)	
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Certification; To Be Completed by Physician/Medical	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 gnonths? 1	b. Due to (or as a consect. C. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Pregnant at time of sect. Sei Hospital: 1 Inpatient 2 Author Sei Place of Injury - At building, etc. (Special Sect. (Special Sect.) 2 Physicien: To the best of my k exeminer: On the basis of examinand manner stated.	equence of): eq	Ectopic pregnancy Other (specify) Underlying cause given Cant	in Part I. 26. Place of Death (Company) 27. Nursing Home 28. 2 X No St. 28. date and place, and inion, death occurred number	23e. Did toba 1 Yes 24a. Was an autopsy performe 1 Yes 2 Check only one) 5 Residen 1. Describe how abject 1 Location (Stree City or Town, ousetown 1 due to the cau at the time, dat	23d. Date of dei Month 23d. Date of dei Month 22 No 3 Pr 24b. Were au prior to death? 1 Ves 26 Other (Specinjury occurred Eell et and Number or Rustate) 1 Road, Bo se(s) and manner as e and place, and due 3. Date signed (Month) D Vewbey	othe cause of death? obably 4 Unknown stopsy findings available completion of cause of 2 No cify) ural Route Number, consboro, MD is stated. o to the cause(s) h. Dey, Year)

imeni di nealin and Menial	nygierie	-the	ull's	-0.7
ificate of Death	Reg. No.	\cap	\cap	Ę,
licale of Dealif	Reg. No.	U	U	5.

lene		O	-	1	17	-	0	
eg. No.	U	U	J	1.3	3	D	Ö	

	Physi /Med Exam	dical
	Funera Directo	
Manyland	-f ehow fied at	tor

permit. Pages 1 and 2 should be filed within 72 hours after death with the I Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23s or 28s ery laipury or other fraumatic event, the Medical Examinar must be notified. Baltimore, Maryland 21215-0036 Physician /Medica Examine

Charles W. Baker

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

10 Registrár

	1 - For State Registrar	30	ate of ivid	arytari		rtificate			vientai n	Reg. No	nns	43682
	1. Decedent's Name (First, M	liddle, Last)							2. Date of D	eath Da	y Year	3. Time of Death
cian Iical	Charles	Willian	n Bak	.er					Decembe			2:45p. M
iner	de Capilles Nome (16 and instit	ution, give street	and number)			4b. City, To	own, or Lo	cation of Death	1	4c.	County of Deat	h
	Doctors Hos	pital				Lanh	am			P	rince G	eorges
ıl r	5. Social Security Number 578-60-3531	6. Sex ₩XM		e (In yrs. I 61	ast birthday) Yrs.	If Under 1 Months		Under 24 Hrs. Hours Min.		irth Day, Ye <i>ar)</i> 23,	9. Birt 200 1944Was	hplace (State or Foreignitry) n.,D.C.
	Usual Residence of Deceden											
٠,				TOC. City	r, Iown or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 No
5	MD. Pri	nce Geor	rges	0xc	on Hil	1						T Tes 241 No
- ire	10e. Street and Number					10f. Zip Code					izen of What Co	untry?
16	5823 Ottawa	St.					207	45			U.S.A.	
le l	11. Marital Status		as Decedent		S. 13.	Was Decede	nt of Hispa	anic Origin? (S Mexican, Puert	pecify Yes or No Rican, etc.)	lo-	14. Race - Ame Black, White	
Completed by Funeral Director	1 □ Never Married 2 □ 1 3 □ Widowed 4 □ Divor	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No 11 Yes, Give 1 96						Specify:	,		Specify: B1	
pieted	15. Dece (Specify only hi Elementary/Secondary (0-1	dent's Education ghest grade con	n npleted) college (1-4or 5		16a. Dece (Give life.	dent's Usual kind of work DO NOT use	Occupatio done duri retired)	n ng most of wor	king	16b. K	ind of Business/	Industry
E 0	12	(2)	ollege (1°401 ;	,*,	Mea	t Cutt	er(Ma	gr)		P	rivate	
Be		die, Last)					18	. Mother's Nan	ne (First, Middl	e, Maiden	Sumame)	
ToB	Rufus Baker							Daisy	Walkup)		
-	19a. Informant's Name/Relat	ionship (Type, P	Print)		19b. Mailir	ng Address (Street and	Number or Ru	ral Route Num	ber, City o	r Town, State, Z	(ip Code)
	Gwen Baker(Si	ster-in-	-Law)		203 A	ragona	Dr.	.Ft.Was	hingtor	.Md.	20744	
	20a. Method of Disposition			20b. P	ace of Dispo	sition (Name	of		Date		ocation - City or	Town, State
	1 XBurial 2 Cremati 4 Donation 5 Othe	or (Specify)	val from State		coln M			1-4-			tland,Mo	
KIIIKE	21. Signature of Funeral Sen	The Hotelson	hnson								Home,P.A Hills,Mo	A. 1.20748'
cai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Inferval Between Onset and Death MONTHS	
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 4	yes, outcome □Live birth □Pregnant at □Unknown	2 Fetal	death 3[Ectopic preç					23d. Date of deli Month	very Day Year
d by	Part II. Other significant con	ditions contribu	ting to death b	ut not resu	ilting in the u	nderlying cau	se given i	n Part I.		tobacco u		the cause of death? bably 4 Unknown
Completed									per	s an opsy formed?	24b. Were au prior to death?	topsy findings available completion of cause of
Be		dical					26	S. Place of Dea	th (Check only		1 10103	2 2 140
ToB	examiner?	Hospit	tai:	ent 2 🗆	ER/Outpatier	it 3 DOA	Other				6 Other (Spec	of a
on: T	27. Manner of Death 1 🖸 Natural 5 🗆 Pe		Ba. Date of Inju (Month, Da		28b. Time o Injury		. Injury at Work?		28d. Describe			** f)
rtifical	2 Accident Inv 3 Suicide 6 Co 4 Homicide de	ould not be termined 28	e. Place of Inj building, et	ury - At ho c. (Specify	me, farm, str			2 No	28f. Location City or To	(Street an own, State	d Number or Ru)	ral Route Number,
Medical Certification:	29a. Certifier 1 Cert (Check only 2 Medione)	ifying Physician	n: To the best On the basis o	t examinat	wledge, deat ion and/or in	n occurred at vestigation, in	the time, on my opinion	date and place on, death occu	, and due to the	e cause(s) , date and	and manner as I place, and due	stated. to the cause(s)
Me	29b. Signature and title of cer					29c.	icense nu	ımber		29d. Dat	e signed (Month	Day, Year)
		Alau, MI	D			Do	0058275 12-28-05					
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										
	PARAND ALA 31. Date filed (Month, Day, Y	VI, MO	T			r ryn	HAM	MD 20	子06			
itate strár	101104		32. Registr	ai s Signal	Span	E)						

			1- State of Maryland / Department of Health and Maryland / Department of Death Certificate of Death		ene 005	43683
	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, Last) Sadie Leona Belle Bull 4a. Facility Name (If not institution, give street and number) Ctr. 4b. City, Town, or Location of Death	2. Date of Death Month 12	Day Year 31 2005 4c. County of Dea	
	Funeral Director		Westminster Nursing & Rehab. Westminster	8. Date of Birth (Month, Day, Y		toll thplace (State or Foreign buntry) Iaryland
	be filed within 72 hours after death with the Maryland all Hygiene. And Hygiene do that than "natural", or lieme 23a or 28a-f show other than "natural", or lieme 23a or 28a-f show event. The Medical Exercises most be notified at	Funeral Director	10a. State 10b. County 10c. City, Town or Location MD Carroll Hampstead 10e. Street and Number 1326 N. Main Street, Apt. 5 21074 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? In U.S. Armed Forces? In U.S. Armed Forces? In U.S. Specify Cuban, Mexican, Puerto Force 1 1 U.S. 2 No.		USA 14. Race - Ame Black, Whit	erican Indian,
121215-0036	filed within 72 hours a Hygiene. other then "netural", o	Completed by	3 ☑ Widowed 4 □ Divorced	ng	b. Kind of Business	
Marylan	2 should be and Mental ie marked o aumatic eve	To Be	17. Father's Name (First, Middle, Last) William H. Wisner 19a. Informant's Name/Relationship (Type, Print) Shirley Smith - Daughter 18. Mother's Name Cather 19b. Mailing Address (Street and Number or Rural) 15310 Old Hanover R	ine He	edrick Dity or Town, State, .	
ä	permit. Pages 1 and 5 Department of Health Important: if Item 27 any njury or other tra once.			4-06 U	c. Location - City or	Town, State
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Hamps t r respiratory arrest		21074 Approximate Interval Between Onset and Death
	ate be executed hysicien and the buriat-transit	dical Examiner	Sequentially list conditions, Lary Lacons to medials cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.			10 zign
ă	death e atter d for u	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of de Month	ivery Day Year
ecords, P	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		<u> </u>	o the cause of death?
Ĭ	The ate h page	e Completed			prior to	utopsy findings available completion of cause of
ō	Phys this ral di	To B			ee 6 Other (Spe injury occurred	cify)
Division	To the Hospitel or Attending within 24 hours effer death. To the Funerel Director: After completely filled in by the fune.	il Certification;	4 Homicide building, etc. (Specify)	City or Town, S		
	To the Hospitel Within 24 hours e To the Funerel Completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated. 29b. Signature and title of certifier 29c. License number	ed at the time, date	and place, and due	h, Day, Year)
	Sta Registi		30. Name ind address of person who completed cause of death (Item 23a) (Type, Print) Tohn Middletin CSS Pode Rd, Westmin 31. Date filed (Month, Day, Year) JAN 0 4 2006 Melane & Assault	neton	MD	21157

David S. Booth 05-08915 NJM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma			ent of Hea		_	giene Reg. No	CUUD	43684
			Decedent's Name (First, Middle, I	ast)					2. Date of De	aath		3. Time of Death
	Physici /Medio		David Speicher	Booth					Month Decembe	er .	y Year 31 2005	0130 M
	Examir		4a. Facility Name (If not institution, g	ive street and number)		4b. (City, Town, or Loca	ation of Death			County of Deat	
	7		3500 Block Halte	er Road		W	estminste	er		(Carroll	
	Funeral Director		212-17-3968	Sex 7. Ag	e (In yrs. last birt 22	Yrs. Mon		Under 24 Hrs. ours Min.	8. Date of Bir (Month, Da Dec 1	th ay. Year) L 198	9. Birtl Co	hplace (State or Foreign untry) MD
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	Maryli 1 eho	ō	MD Carr	coll		lestmir	ster					1 ☐ Yes 2 No
	288-	Director	10e. Street and Number			101	. Zip Code			10a. Cit	izen of What Co	untry?
	h with	<u>-</u>	3401 Green Mead	low Lane			21158				USA	,
	deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was D	ecedent of Hispar specify Cuban, M	nic Origin? (Sp	ecify Yes or No	o-	14. Race - Ame	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "neture!, or iteme 23a or 28a-1 ehow event, Ita Medical Examinational be multified at	þ	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced		No			оесіfу:	nican, etc.)		Specify: W	hite
Ģ	72 ho	Completed	15. Decedent's (Specify only highest of		16a.	Decedent's	Usual Occupation	a most of word	ing	16b. K	ind of Business/l	ndustry
2	ithin 7	npie	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. DO NO	f work done during T use retired)	g most or work	ing			
2	filed wi Hygien other th	ပ္ပ		3		Stude					esleyan	College
<u> </u>	tal H d off	Be	17. Father's Name (First, Middle, La	•			1		e (First, Middle	, Maiden	Sumame)	
<u>\frac{2}{3}</u>		은	David Lippincot					arah Sp				
, Maryland	12 g		19a. Informant's Name/Relationship Sarah Speicher F		34	Mailing Add	ress (Street and Neen Meado	ow Lane	al Route Numb • Westn	er, City o ninst	er, MD	^(ip Code) 21158
ore	es 1 and of Healt fitem 2: r other t		20a. Method of Disposition 1XXBurial 2 □ Cremation 3		20b. Place of		(Name of or other place)	1	Date	20c. Lo	ocation - City or	Fown, State
Ĕ	Pages ment of ant: If it		4 Donation 5 Other (Spec		Westmi	nster	Cemetery	y 01/0	6/2006	Wes	stminste	r, MD
Baltimore,	permit. Pages 1 Department of H important: if ite eny injury or ott		21. Signature of Funeral Service Lice	ensee	_		ts Fune Washingt					
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused	the death. Do n						Jear / III	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Pus t							Onset and Death
	/Medical		resulting in death)	- a.	a consequence of		J U =					
I	Examiner	i	Sequentially list conditions	b								
	ם ב	iner	Sequentially list conditions, if any, localing to inner educate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a nonsequence o	of):-						
	ecute and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c								
60,	cate be executed physician and the burial-transit	E		Due to (or as	a consequence o	or):						
98/60	physicate the l	dical	•	d								
×	the death certifi by the attending pached for use as	/Me	IF FEMALE:	23c. if yes, outcome	of pregnancy						33d Data of dala	
Rox	atter after of for u	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐Ectop 5 ☐ Othe	ic pregnancy (specify)			1	23d. Date of deli- Month	Day Year
o.	by the destached	ysi	1 ∐ Yes 2 □ No 9 □ Unknown	9□ Unknown		0 0 0	(4,500.1)/					
J.	s that ned b	by P	Part II. Other significant conditions	contributing to death b	ut not resulting in	the underlyi	ng cause given in	Part I.	23e. Did t	obacco u	se contribute to	the cause of death?
Vital Records,	w requires to been signed should be								1 🗆 '	Yes 2	5No 3□Pro	bably 4 Unknown
ပ္ပ	The law requires that te has been signed b age 2 should be dete	ompleted							24a. Was	an	24b. Were aut	opsy findings available
Ĕ	The lav	Eo								rmed?	prior to o	ompletion of cause of 2 □ No
<u> </u>	40 ct	0	25. Was case referred to medical				26.	Place of Deat	Check only of	2□No	1 Barres	2 L No
	ysician: vis certific director,	ToB	examiner? 1⊕Yes 2□ No	Hospital: 1 ☐ Inpatie	nt 2 ER/Out	tpatient 3	Other			-	Other (Spec	(tv) Scene
n 0	ding Phy h. After thi funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da		ime of	28c. Injury at Work?	1/	28d. Describe	how injur	y occurred	1750 वराज्या
DIVISION	ttendi death. ctor: A / the fu	cati	2 Accident investigati	10 11-0	5	16 A M	1 Tes	2 No	Much	OE	con In	18 Dir uns
⋛	br Ati	Certification;	3 Suicide 6 Could not 4 Homicide determine	d 288. Place of my		rm, street, la	ctory, office		City or Tox	wn, State)	ral Route Number,
_	Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certific tely filled in by the funeral director,	ဒီ	00- 0-4% 4F-0-4%		nusy							THINSON MO
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edicai	29a. Certifier 1 ☐ Certifying F (Check only one) 1 ☐ Certifying F XIX Medical Ext	Physician: To the best of aminer: On the basis of and manner sta	examination and	, death occur Vor investiga	red at the time, da tion, in my opinion	ate and place, n, death occuri	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within I	Med	29b. Signature and title of certifier	1			29c. License num	nber		29d. Dat	e signed (Month	, Day, Year)
	10		> UDUA TO	me Kril	e u	m	OCME	7			mber, 3	•
١	NJ		30. Name and address of person who	o completed cause of d	eath (Item 23a) C	Type. Print)	COM	2		Dece	muer, J.	1, 2007
	7		MARGOMIN	D-1406			.11 Penn	Street	Balti	more	, Marvl	and 21201
	Sta		31 Date filed (Month, Day, Year)		ar's Signature						,	
	Registr	ar	JAN 0 4	2008	eve #	Lan	1.					

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Ma	aryland / De _l		Health and	Mental Hygi	_	43685
y'a	Physicia	an	1. Decedent's Name (First, Middle, L		,			2. Date of Death		3. Time of Death
100	/Medic	al	Michael Lippinco 4a. Facility Name (If not institution, gi			4b City Town	or Location of Dea	December	31 2005 4c. County of Death	0130 M
ļ.,	Examin	er	3500 Block Halter				inster		Carrol	
	Funeral Director		5. Social Security Number 6. 212-90-0268 Usual Residence of Decedent	Sex 7. Ag 1 2 XM 2 □ F	e (In yrs. last birthda 35 Yrs.	Months Day			9. Birth	nplace (State or Foreign untry) MD
	nyland how		10a. State 10b. County		10c. City, Town or					10d. Inside City Limits
	he Ma	Director	MD Carro)11	Westm	inster				1 🗋 Yes 23(2) No
	death with the Maryland me 23a or 28a-f ehow r must be notified at	<u>ו</u>	10e. Street and Number 3401 Green Mead	low Lane		10f. Zip Code 21	.158	10	g. Citizen of What Coo USA	untry?
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Decedent of	Hispanic Origin?	Specify Yes or No- rto Rican, etc.)	14. Race - Amer Black, White	
21213-0036	172 hours after death with the Marylar "neturel", or iteme 23a or 28a-1 ehow silcal Examinar must be notified at	by	1 🛣 ever Married 2 🗆 Married 3 🗆 Widowed 4 🗎 Divorced	1 ☐ Yes 2 ☐ Yes If Yes, Give Year or Dates:	No	1 ☐ Yes 2 🛣 N			0	nite
2	within 72 h ene. then "netu	lete	15. Decedent's I (Specify only highest g	Education rade completed)	(Gi	edent's Usual Occi re kind of work don DO NOT use retii	e during most of wo	orking 1	6b. Kind of Business/I	ndustry
717	d withi	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Salesman	·		Political	Affairs
yland	uid be filed within 72 ho fental Hygiene. Ked other then "netur tic event, the Medical	To Be C	17. Father's Name (First, Middle, Las David Lippincot		VM		18. Mother's Na	me (First, Middle, M Speicher	laiden Sumame)	
Mary	2 should and Men ie marke raumatic	. 9	19a. Informant's Name/Relationship						City or Town, State, Z	
dî.	s 1 and f Health item 27 other tr		Sarah Speicher Bo	oth/Mother	20b. Place of Dis	position (Name of	1 - 1		nster, MD Oc. Location - City or 1	21158
Ē	Pages ent of nt: if it ry or o		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		cemetery, c	ematory or other p	1		Westminste	
Baltimor	permit. Pages 1 Depertment of F Important: if Ite eny Injury or ot once.		21. Signature of Enteral S. vice Lice	-				ne and Cha		E. IVID
D	#0 E 9 9		fala)			112 Washi	ngton Roa	ad Westmi	nster, MD	21157
)	Physician /Medical		23a. Parf 1. Ent if the disease, or conshock, or mean failure. List onlimmediate Cause if hal disease or condition resulting in death)	y one cause on each ling	Tnjur	nter the mode of dy	ying, such as cardia	ic or respiratory arre		Approximate Interval Between Onset and Death
	Examiner			Due to (or as	a consequence of):					
	D ==	ner	Sequentially list conditions, if any, leading to finite date cause. Enter Underlying Cause (Disease or injury	b. Due to (or se	a consequence of:					
/e0,	e be executed rsicien and e burial-transit	I Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a consequence of):					
68/6	A 2 0	dical		d						
O. Box	at the death certificate by the attending phy tached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	☐Ectopic pregnan	су		23d. Date of deliving Month	very Day Year
7.	s that th pred by e detacl	y Phy	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause g	given in Part J.	23e. Did toba	acco use contribute to	the cause of death?
ords	w requires that been signed b should be det							1 🗀 Yes	s 2 ZiNo 3 ☐ Pro	obably 4 Unknown
al Records,	The la ete hes page 2	Completed						24a. Was an autopsy perform	ed? prior to o	opsy findings available ompletion of cause of 2 No
Vita	Physician: this certific ral director.	To Be	25. Was case referred to medical examiner? 1 ★ Section 2 □ No	Hospital:	ent 2 ER/Outpat	ent 317 DOA		ath (Check only one	nce 6 Other (Spec	ωΛ1 6 a 2 . a 2
פַ	ng Phys ter this neral di		27. Manner of Death	28a. Date of Inju	ry 28b. Time	of 28c. Inj		28d. Describe how		MAT Scene
<u>o</u> s	tendir leath. tor: Af the fur	catlo	1 □Natural 5 □ Pending 2 ■ Accident investigati 3 □ Suicide 6 □ Could not	on 12-31-0	5 011	6 AM 10	Yes 20 No	Auto	Accident	
Division	i or At efter o Direct i in by	Certification:	4 Homicide determine	28e. Place of Injubulding, et	ury - At home, farm, c. (Specify)	street, factory, office	9	City or Town,		mesta vite
	ospita hours unerai ly filled		29a. Certifier 1☐ Certifying F	Physician: To the best	of my knowledge, de	ath occurred at the	time, date and place	e, and due to the car	use(s) and manner as	stated.
	To the Hospital or Attending Pt within 24 hours eliter death. To the Funeral Director: After it completely filled in by the funeral	Medical	one)	aminer: On the basis of and manner sta	ated.					
		<	29b. Signature and title of certifier	1/1/		29c. Licei	nse number		d. Date signed (Month	,
	WSL		30. Name and address of person wh	o completed cause of d	leath (Item 23a) (Typ	e, Print)	10519 &		anuary 01	12006
	4		Herbert P. Handergo	0 20 WO 90	173 Manche	Her Rd 1	Moucheste	mo 2	1102	
	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signature	house .				

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** Thomas Barbour 1800 PM 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** REGIONAL 50/15644 Nicomico TININSULA Medical If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/27/1918 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 XM 2 ☐ F 87 077-32-6391 Director Scotland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ehow r then "naturel", or items 23s or 28s-f ehover the Modical Examiner must be notified at Wicomico Maryland Salisbury 1XXYes 2□No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30516 Waycroft Drive 21804 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No white Specify: by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Manager Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be for John Barbour Agnes Cowie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau once. 100 Thomas Barbour/son 611 Truston Rd., Annapolis, MD 21401 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 1/4/06 4 □ Donation 5 □ Other (Specify) Salisbury Crematory Salisbury, MD 21. Signature of Funeral Service Lice see 22, Name and Address of Facility HOLLOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 à 7. Enter the disease, or complications that cause the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, sizek, or heart failure. List only one cause on ear line. Interval Between Onset and Death tracediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) -transit and Due to (or as a consequence of): attending physician a for use as the burialiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Ö sate has been signed by the page 2 should be detached Physi 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an rmed? 223 No 1 ☐ Yes Vital funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No 3X DOA 1 🗌 Inpatient 2 ER/Outpatient of 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: Division or Attending 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospital o within 24 hours att To the Funeral Dit tilled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George C 31. Date filed (Month, GALIFIA NAKIS 100 E. CAVIOIT ST. M.D. 1 0 4 2006 32. Signature State Registrar

Thomas

			1 - For State of Maryland / Registrar	•	irtment of Ho tificate of L			jiene eg. No. (005	43687		
37	Physici /Medic		Decedent's Name (First, Middle, Last) ALTA LYNN	соок			2. Date of Dea Month	Day	Year Year	W STEM		
4.	Examin	3	4a. Facility Name (If not institution, give street and number) DOCTOR S HOSPITAL		4b. City, Town, or LANHAM			PRI		EORGE 'S		
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 S F 64 Usual Residence of Decedent	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day OCTOBER	Year) 14 1	9. Bi	rthplace (State or Foreign country) WEST VIRGINI		
	the Maryland 28a-f show	rector	10a. State 10b. County 10c. City, To		LVILLE			10a. Citíze	n of What O	10d. Inside City Limits 1 X Yes 2 □ No		
036	s within 72 hours after death with the Maryland Jiene. r than "natural", or Items 23s or 28s-1 show the Alcal Eracilizat must be redified at	by Funeral Director	11.411 LAKE ARBOR WAY # 608 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 11. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	If	20716 Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)			nerican Indian, ite, etc. BLACK		
Maryland 21215-0036	d within giene. r than "	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+) 2 yrs 17. Father's Name (First, Middle, Last)	(Give I life. E	lent's Usual Occupa kind of work done d DD NDT use retired) RETARY	urina most of worki		GOV	of Busines			
yland	e d la b	To Be	WILLIAM R. PALMER			GENEVA	POINDEX	TER				
	1 and 2 Health a em 27 is		JOSEPH COOK SR./HUSBAND 1 20a. Method of Disposition 20b. Place	1411 of Dispos	g Address (Street a LAKE ARB sition (Name of	OR WAY #6		HELLI	VILLE,	Zip Code) 20716 MARYLAND r Town, State		
Baltimore,	t. Page: rtment o rtant: If rjury or		1 State 2 Cremation 3 Removal from State	ONY	natory or other place CEMETERY . Name and Addres	1/3/2				ARYLAND AL HOME		
B	permi Depe Impo	. 1	23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.		474 LANDO				RYLANI	D 20785 Approximate Interval Between		
68760,	Find physician and physician and physician and physician and sthe purial-transit	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Acute Respiratory Failure Due to (or as a consequence of): Bilateral Pneumonia Due to (or as a consequence of): Coronary Artery Disease Due to (or as a consequence of):									
P.O. Box 6	The law requires that the death certific: ste has been signed by the attending plage 2 should be detached for use as I	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)			230	d. Date of de Month	elivery Day Year		
	w requires that been signed b should be deta	ρ	Part II. Other significant conditions contributing to death but not resulting Diabetes mellitus Hypertension	g in the ur	nderlying cause give	on in Part I.	1 🔯 Y	es 2 🗆 1	No 3□F	to the cause of death? Probably 4 []Unknown		
Vital Records,	an: The law tificete has I tor, page 2 s	e Completed	chronic renal Insufficiency 25. Was case referred to medical			26. Place of Death	24a. Was a autop perfor	sy med? 2 No	prior to death?	autopsy findings available completion of cause of		
Division of Vi	ng Physici Ater this cer Ineral direc	Certification: To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/C 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	o. Time of Injury	28c. Injury Work	ar: 4 Nursing Ho	me 5□ Resid 28d. Describe h	ence 6 [ow injury o	occurred			
Div	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to		4 Homicide determined 255. Place of Injury - At norms, building, etc. (Specify) 29a. Certifier 1 X Certifying Physician: To the best of my knowled	dge, death	n occurred at the tim	e, date and place,	City or Tow	n, State)	nd manner a	Rural Route Number,		
	To the Ho within 24 I To the Fu completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated. 29b. Signature and title of certifier Until 2 Medical Examiner: On the basis of examination and manner stated.	and/or inv	29c. License	number	red at the time, o	date and pl	signed (Mor	nth, Day, Year)		
2	(5)		30. Name and address of person who completed cause of death (Item 23a	0132	Landove	r Rd.	Chever	lu I	no.	20785		
No. of the last	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JAN 0 4 2006	free	V		- 1	1		······································		

			toto of Maniford / Dans		-	-
		_ State	tate of Maryland / Depa	artment of Health and IV tificate of Death	/	(HH) 40000
-		Registrar 1. Decedent's Name (First, Middle, Last)		lineate of Death	Reg. No.	
Physicia	ু an	1	Turniana C	0	Month Da	3. Time of Death
/Medic	al		Junior C	coper		29 2005 1727 M
Examin	er	4a. Facility Name (If not institution, give stree	16	4b. City, Town, or Location of Death EASTON	44	C. County of Death TALLOT
**************************************) ja	THE MEMORTAL 5. Social Security Number 6. Sex,	#OSPITAL 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	
Funeral		5. Social Security Number 6. Sex, 12 M	2 F G 4 Yrs.	Months Days Hours Min.	(Month, Day, Year	
Director	1	Usual Residence of Decedent	0 /		Aug.12,14	141 Maryland
/land		10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
Man Man	ţō	MD Dorches	ster Cam	buidge.		1 Des 2 No
4 st	irec	10e. Street and Number		by, dge	10g. C	itizen of What Country?
Ind 21215-0036 be filed within 72 hours after death with the Maryland at Hygiene. d other then "natural", or items 23e or 28e-f show event, the Maulical Exatt fact must be notified at	Funeral Director	555-Greenwa	and Avenue	21613		USA
g g da c	Jer	11. Marital Status 12.1	Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp if Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
after or the	3	1 Never Married 2 Married	I Voc 2 tokio	1 ☐ Yes 2 12 No Specify:	Alcan, etc.)	Black, White, etc.
ours all,	þ	3 Widowed 4 Divorced	Year or Dates:	TEL TES ZERNO Specily.		Specify: Black
72 hours	Completed	15. Decedent's Education (Specify only highest grade co	on 16a. Dece	dent's Usual Occupation kind of work done during most of work	16b.	Kind of Business/Industry
2 igh	du		College (1-40r5+)	kind of work done during most of work DO NOT use retired)	· ·	1 0
C wed w	S	8.	Me			ood Processing
yland 21 build be filled wi Mental Hygien arked other th	Be	17. Father's Name (First, Middle, Last)	1.	à	e (First, Middle, Maide	
Va outd Men Men arks	မ	Leroy U	lard	EMM		nnson
Maryland 21215-0036 d.z. should be filed within 72 hours aft the and Marell Hygiens for the marked other then "natural; or traumatic event, the Mudical Exemptina in the Mu	k li	19a. Informant's Name/Relationship (Type,		ng Address (Street and Number or Run	1	1 - 1 - 1 - 1 - 1 - 1 - 7
e, N 1 and 1 and Health 10m 27			Oper 355	-Greenwood AV		
Ore Des 1 Or H or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo	comptoni cro	matory or other place)		Lo de de City or Town, State
altimore, mit. Pages 1 a partment of He portant: If New y Injury or othe		4 ☐ Donation 5 ☐ Other (Specify)	Bethel	Cemetery /	4/06 Can	ubridge MD.
Baltimore, Maryland 21215-0 permit. Pages 1 and 2 should be filled within 72 h. Department of Health and Mental Hygiene. Important: if item 27 le marked other then "naturally july or other traumatic event, the Mudical any Injury or other traumatic event, the Mudical ange.		21. Signature of Funeral Service Licensee	21 0 2	2. Name and Address of Facility	Me, P.A.	0 /
m go = e a		Janelle G	Stewell 5	10 Washington ST	6 Cambri o	dge, MD.21613
30 e	Ů.	23a. Party. Enter the disease, or complicati shock, or heart failure. List only one c	ons that caused the death. Do not en ause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Hyrotenino			Onset and Death
/Medical		resulting in death)	Due to (or as a consequence of):			
Examiner	8	Sequentially list conditions b. —	Kulyman Eder	18		
₽ ≒	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a confe uence of):			
760, le be executed /sicien and e burial-transit	am	Cause (Disease or Injury that initiated events resulting in death) Last	end to lune			
760, te be exercision a surial-		resulting in death) Last	Pue to (or as a consequence of):			
	lical	d	36 847			
of Vital Records, P.O. Box 68 Physicien: The law requires that the death certifical this certificate has been signed by the attending phy ral director, page 2 should be detached for use as th	by Physician/Med	IF FEMALE:				
Box eath cert attendin for use	lan/	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		23d. Date of delivery Month Day Year
D. E. se der	Sic	1 Type 2 TNo	4 Pregnant at time of death 5 [9 Unknown	Other (specify)		
P.O. BOX that the death cer ed by the attendir detached for use	F.		usting to death but not condition in the	and add the second second to Dard I	220 Did tobacco	use contribute to the cause of death?
S, Frestha	b	Part II. Other significant conditions contrib	during to death but not resulting in the c	indenying cause given in Part I.		2 No 3 Probably 4 Unknown
Records,	Completed				1 105	Z NO 3 Plobably 4 Officionin
law law by 2 st	pie				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
The The page	20				performed?	
Vital Fillen: The contificate	Be (25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)	
Division of Vital Records, to attending Physicien: The law requirest affer death. Director: After this certificate has been signed in by the funeral director, page 2 should be	은	1 ☐ Yes 2 ☑ No Hos	1 La Inpatient 2 LEH/Outpatie	nt 3□ DOA Other: 4□ Nursing Ho	ome 5 Residence	6 ☐Other (Specify)
E g eige		27. Manner of Death 1 Manual 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how in	jury occurred
/ision Attending r death. ector: After	Certification:	2 Accident investigation		M 1 Yes 2 No		
ivisite der der der der der der der der der de	Ĕ	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
C Ital of irs aff						
dosp t hou Tune ely fil	edicai	(Check only 2 Medical Examiner	an: To the best of my knowledge, dea: On the basis of examination and/or if	th occurred at the time, date and place, by estigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated. Indiplace, and due to the cause(s)
Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tu	Medi	one)	and manner stated.			
To To	2	29b. Signature and title of certifier		29c. License number	29d. C	Date signed (Month, Day, Year)
		KAIND		14005577-C	, 12	29 05
		30. Name and address of person who comp	pleted cause of death (Item 23a) (Type	Print) Dr. Faith Jus	tine Jaber	s-Matzoni
		31. Date filed (Month, Day, Year)	7 33 Booling of Con 47	W MO.		
St Regist	ate		32. Registrar's Signature	South		
10913		AUII A C -	THE PROPERTY OF THE	AND ENGINEER		

			1 - For State Ragistrar	State of I		d / Dep		of He	ealth ar			•		43689
	Physicia	an	Decedent's Name (First, Middle, La								Date of Death Month	Day	Year	3. Time of Death
	/Medic	al	Richard H. Cro		er)		4b. City.	Fown, or	Location of		Dec	31 2 4c. County	005	12:20 AM
	Examin	er	5949 Conover		,		Harney				Carroll			
	Funeral		5. Social Security Number 6. S		Age (In yrs.			1 Year	If Under 24	4 Hrs. 8. Min.	Date of Birth (Month, Day, Y		9. Birthr	place (State or Foreign
	Director		212-72-7194 Usual Residence of Decedent		+6	Yrs.					une 20			PA
	ryland how		10a. State 10b. County		10c. Ci	y, Town or I	Location						1	0d. Inside City Limits
	he Ma 28e-f s	ecto	MD Carro	<u> </u>	H	arney								1 Yes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If tien 27 is marked other then "naturel; or Items 23e or 28e-f show eny injury or other treumetic event, the Modical Examination must be notified at once.	Funeral Director	10e. Street and Number 5949 Conover	Rd.			10f. Zip		21787			. Citizen of W USA	/hat Cour	ntry?
	death	nera	11. Marital Status	12. Was Decede Armed Force	nt Ever in U	.S. 13	I. Was Deced					14. Race		can Indian,
0	or Ite	by Fu	1 Never Married 2 Married	1 ZYes 2 (□No 1		1 Tes, spec		Specify:	Риепо ніса	an, etc.)	Specify.	k, White,	
2000-	hours	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	Year or Date	ıs: L		edent's Usua				16	b. Kind of Bu		White
<u> </u>	hin 72 9.	Completed	(Specify only highest gr. Elementary/Secondary (0-12)	ade completed) College (1-4d	or 5+)	(Giv	e kind of wor DO NOT us	k done dı	uring most o	of working	, ,	o. rend of ba	3111033/111	dustry
7	led wit ygien her th	Con	12			Truc	ck_Dri	ver				Tran	s po :	rtation -
מום	d be fill ntal H ed otf	Be o	17. Father's Name (First, Middle, Last	,					_					
Š	should nd Me mark metic	2	Richard W.Cro			19b. Mai	iling Address				ines T oute Number, C			Code)
, Ma	and 2 salth a n 27 is		Linda Thomas-	-Mother		1-:					aneyto			
ole	ges 1 t of He if iten or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from Sta		Place of Dispendence of Dispendence	position (Name	e of her place	,)	Date	20	c. Location -	City or To	own, State
Бантпо	it. Pag rtment rtent: njury		* 4 □ Donation 5 □ Other (Specia	<i>fy</i>)	Ca		Crem			/3/06)	Hamps	tead	d,MD
מ	Depa Depa Impo eny ir		21. Signature of Funeral Service Lice	1 S. F.	0.	(/	22. Name and		Sales Sales	l. Mari	. T. a. N. a.	. 731	. 7	17340
	100	8	23a. Part1. Enter the disease, or comshock, or heart failure. List only	aplications that caus	sed the deat								tres	Stown, PA Approximate Interval Between
1	hysician		Immediate Cause (Final disease or condition	MA		NAV	TA	STI	ZOCY	YTO	m A			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a conseq	- -								THEMO
		-e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	as a conseq	uence of):								
	uted d ansit	Examiner	that initiated events	C		,								
Ž	rate be executed hysician and the burial-transit		resulting in death) Last	Due to (or	as a conseq	uence of):								
00/00	physic the b	dical	•	d									-	
Ď X O	The faw requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor								23d. Date	of delive	arv
Ď	death ne atte ad for	Physician/M	in the past 12 months? 1 □ Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknowr	t at time of d		☐Ectopic pre☐ Other (spe					Mon		Day Year
<u>r</u> Ο	d by the	Phys	9 □ Unknowh `			- 10 to - 10 at								
, D	signer d be d	d by	Part II. Other significant conditions	contributing to death	n but not res	uiting in the	underlying ca	iuse giver	n in Part I.					ne cause of death? ably 4 Unknown
ecords	w requ	lete								-	24a. Was an			psy findings available
r L	sicien: The law s certificate has b lirector, page 2 s	Completed									autopsy performe	#? □ pi	rior to cor eath?	npletion of cause of
VII	sien: artifica ctor, p	BeC	25. Was case referred to medical examiner?						26. Place of		1 ☐ Yes 2 Z heck only one)	INO		2 10
5	Physic this co	၉	1 ☐ Yes 2X No	Hospital:		ER/Outpation		A Other	r: 4 🗆 Nursi	ing Home	5 Residenc	e 6 □Othe	r (Specify	1)
5	th. : After funer	tion	27. Manner of Death 18 Natural 5 Pending 2 Accident investigatio	28a. Date of I	Day Year)	28b. Time Injury	M 28	c. Injury Work? 1 □ Y	at ? es 2⊡No		Describe how	injury occurre	ed .	
DIVISION	Atten er dea ector by the	Certification:	3 Suicide 6 Could not b	28e. Place of	Injury - At he	ome, farm, s	street, factory,			28f.			r or Rura	I Route Number,
5	itel or irs afte rel Dir led in										City or Town, S			
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	dical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exal	hysician: To the be minar: On the basis and manner	s of examina	wiedge, dea tion and/or i	ath occurred a investigation,	it the time in my opi	e, date and p inion, death	place, and occurred a	due to the caus t the time, date	e(s) and mar and place, a	nner as st nd due to	ated. the cause(s)
	vithin vithin comple	Med	29b. Signature and title of certifier	and manner	stated.		29c.	License	number		29d.	Date signed	(Month,	Day, Year)
	Λ.		1 time	wk. C	5 Celu	w [iii		DE	3166	00	01	03/2	000	0
	WSZ		30. Name and address of person who	completed cause of	of death (Item	23a) (Type	e, Print)							
	8		31. Date filed (Month, Day, Year)	LVIN II			1 570	W Ca	SAVE	מטפ ו	Wesm	1 W ST	ca	3216 AM
	Sta Registr		IAN 0 4	2005 2	rar's Signa	Kule	Some	0						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Corbett, Jr. Willis Lester 30, 2005 Dec. 2:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FUTURECARE PINEVIEW Clinton P.G. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1₩M 2□F 75 579-40-1182 Director 1-9-30 N.C Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County ocrant: If item 27 is marked other than "netural", or Items 23a or 28a-f show injury of other traumatic event. If a Medical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Director MD. Upper Marlboro P.G. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13310 New Acadia Lane #108 20746 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes XXNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Š 3€3Vidowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4or 5+) Security Officer Private 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental int: If item 27 is marked o Willis L. Corbett, Sr. Addie Byrd ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ollie C. Graves/Sister 5509 Hill Way, Suitland, Md. 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) Resurrection Cem. 1/7/06 Clinton, Md. 22. Name and Address of Facility
Hackett's Funeral Chapel, Inc. 21. Signature Funeral Service Licensee War La 814- Upshur Street, N.W. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer with Metastasis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? jo Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be o 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 1□ Yes 2 🔀 No 24 hours after death. • Funeral Director: After this certific elely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No ٩ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 🗶 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 01-03-2006 D 51520 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bahram Pishdad, M.D. 1328 Southern Ave. SE DC 20032 31. Date filed (Month, Day, Year) JAN 0 32. Registrar's Signature State 2006 Registrar

			State	and / Department of Health and N Certificate of Death		2005	43691
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. I	to. 0 0 0	3. Time of Death
	Physici		ANTHONY LESTER COKER	TR		Day Year	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
			ST. AGNES HOSPITAL	BALTIMOR	E		
	Funeral Director		N/A INM 20F	rs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 32	8. Date of Birth (Month, Day, Yea DCCCmbl C	ar) Co	hplace (State or Foreign untry)
	pur *		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Location			10d. Inside City Limits
	Aaryla f sho	ō		BALTIMORE			1 Yes 2 □ No
	288-	Funeral Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Co	
	3a or	Ö	2822 ROSALIND AVENU			USA	,
	deatl	ner	11. Marital Status 12. Was Decedent Ever in Armed Forces?		ecify Yes or No-	14. Race - Ame	
98	ours after death with the Marylan rel', or items 23a or 28a'f show Examiner mart be notified at	y Fu	Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 No Specify:	riidari, etc.)	Black, White	a, etc.
ĕ	filed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or items 23a or 28a-f show int, the Medical Exercit et misst be notified at	d by	3 Wildowed 4 Divorced Year or Dates:		1.0	DE	ACIC
7.	in 72	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16b.	. Kind of Business/	Industry
212	d with Diene.	mo	Elementary/Secondary (0-12) College (1-4or 5+)	INFANT		INFA	HUT
P	be filed within 7: tal Hygiene. od other then "n event, I'm Med	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maid	len Sumame)	
<u> </u>	2 should be to and Mental His marked of reumatic eve	To	ANTHONY LESTER COKER	Shan	ell BR	YANT	
Maryland 21215-0036	ges 1 and 2 should t of Health and Mer If item 27 is marke or other treumatic	l a	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Run	A	0 ;	2443
	t and 2 Health tem 27 i		MOTHER-SHANGL BEYN 20a. Method of Disposition 20th	p. Place of Disposition (Name of	Avenue 20c.	DALTIM Location - City or	CRE MID
Baltimore,	Pages nent of H int: If ite		Burial 2 Cremation 3 Removal from State	cometery, crematory or other place) Cometry Company Cometry Com	4 /		MARYCAND
튶	perrit. Pag Department Important: I any injury o		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	22. Name and Address of Facility	006		
Ba	perrit. Departn Imports any nju		Delduartong per sue	Lynn 900 CATON AVENUE	BALTIM	10RE, MAK	
			23a. Part1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line.	eath. Do not enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician	E III	Immediate Cause (Final disease or condition resulting in death)	PULMONARY HEMORRY	MGE		23 hRS
	/Medical Examiner		Due to (or as a cons	sequence of):			25-66
		e.	Fequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	sequence of):		Di l	43.44
	uted d ansit	Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events	TE IMMATURITY			25% hee
0,	cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a cons				
17 A	cate be physicia the bu	dical	d				
44 89 ×			IF FEMALE:				
2 BO)	The law requires that the death certifi ste has been signed by the attending bage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fregnant at time of	etal death 3 ☐Ectopic pregnancy		23d. Date of deli Month	very Day Year
0,	at the de by the a tached	iysic	1 Yes 2 No 4 Pregnant at time of 9 Unknown	of death 5 Other (specify)			
S, P	that the		Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
~ P	requires een sign nould be	ompleted by	GRADE IIL INTRAVENTR	ICLLAR HEMORRHA	1□ Yes	2 No 3 Pr	obabiy 4 Unknown
oco.	aw requisible been 2 should	piet	HYPOVOLEMIA		24a. Was an	24b. Were au	topsy findin s available
A) E	The tav	Com			autopsy performed	?// death?	of platfor of cause of 2□ No
∑ ita	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?		h (Check only one)		
3/2	sin dill	2		ER/Outpatient 3 DOA Dther: 4 Nursing Ho			cify)
4	ding l	tion	27. Mann f Death 1 Death 5 Pending (Month, Day Year)	28b. Time of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	ijury occurred	
W isi	death death ctor: y the	ertification:	2 Accident investigation 3 Suicide 6 Could not be 28e, Place of Injury - A		28f. Location (Street	and Number or Ru	ral Route Number.
Bivisi	after Dire	erti	4 Homicide determined building, etc. (Sp.	ecify)	City or Town, St.	ate)	
	To the Hospitel or Attending Pl within 24 hours after death. To the Funerel Director: After th completely filled in by the funera	edical C	(Check only 2 Medical Examiner: On the basis of exam	knowledge, death occurred at the time, date and place, ination and/or investigation, in my opinion, death occur	and due to the cause red at the time, date a	a(s) and manner as and place, and due	stated. to the cause(s)
	the the thin 2 the mplet	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number		Date signed (Mont)	
	¥ ¥ ¥ 8		as South 1	M.D. D14955		2 911 -	7 00
	n et		30. Name and address of person who completed cause of death (tem 23a) (Type Print)		4-4,6	2005
Kik	7.11		ARTURO Q. SANTOS.	mb 900 CATON ANE BAL	TIMORE A	MARYLAM	D 21229
	Sta	ate	31. Date filed (Month, Oay, Year) 32. Rigistrar's Si	gnature Acoustics	Training!	7-14	
2	Regist	ar	DHIN T A COOP TOWN	No Proposition			

	•	1	For State Registrar		State of N	Maryland		epartment of F Certificate of a		Mental Hy	giene Reg. No.	05	43692
				(First, Middle, Last)					2. Date of D	eath Day	Year	3. Time of Death
	Physicia /Medic	al -			Fagan Du					Decemb	er 27,	2005	7:59A M
	Examin			'not institution, give ry General				4b. City, Town, o	Location of Death		1 -	ounty of Deat SOMERY	
	-		5. Social Security N			Age (In yrs. Ia:	st birtho		If Under 24 Hrs.	8. Date of B	irth	9. Birt	hplace (State or Foreign
	Funeral Director		359-09-5			89	Yrs	Months Davs	Hours Min.	Aug. 23	,1916	New	Jersey
	pur a	h-	Usual Residence of 10a. State	Decedent 10b. County		10c. City.	Town	or Location					10d. Inside City Limits
	f sho	- 4	Maryland	Montgome	CV			Spring					1 ☐ Yes 2 ☐ No
	r 28a-	Directo	10e. Street and Nun					10f. Zip Code			10g. Citizer	n of What Co	
	23e o	alD	3330 No:	rth Leisu	re World	Blvd.#	815		20906			U	ISA
	tems	Funeral	11. Marital Status	T	12. Was Decede Armed Force	s?		 Was Decedent of H If Yes, specify Cuba 	ispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or N Rican, etc.)	0- 14.	Race - Ame Black, White	
30	irs afte	by F	1 Never Marri	ed 2 Married 4 □ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date			1 ☐ Yes 2 💢 No	Specify:		Sp	pecify: W	hite
21215-0036	72 hou		(Spec	15. Decedent's Edu ify only highest grad			16a. D	ecedent's Usual Occup	ation during most of work	kina	16b. Kind	of Business/	Industry
7	filed within 72 hours after death with the Maryland Hygiene. Ither than "neture!", or Items 23e or 28e-f show ent, the Medical Evantrer must be rediffed at	Completed	Elementary/Seco		College (1-4	or 5+)		Give kind of work done ife. DO NOT use retired memaker	1)		At h	ome	
מ	filed v Hygie other t	e Co	17. Father's Name	(First, Middle, Last)					18. Mother's Nam	ne (First, Middl	e, Maiden Su	imame)	
lan.	uld be Aental rked of tic ev	To B	James La	wrence Fag	gan				Kather	rine M	cMenam	in	
Maryland	2 sho	1		ame/Relationship (7)			19b. N	Mailing Address (Street	and Number or Ru	ral Route Num	ber, City or T	own, State, 2	Zip Code) 20906
e, S	is 1 and 2 of Health a item 27 is other tree		20a. Method of Disp	• Duncan/I		20b. Pla	ice of D	isposition (Name of	1	Date DIV	-	SILVe	er Spring, MD.
פֿר	ages ant of nt: If it y or o		1 🗆 Burial 2	Cremation 3 0		ate		Crematory or other place Crematory	Dec.	.29,200			
Baltimore,	21. Signature Funeral Service Licent 22. Name and Address of Facility Geo. P. K										Kalas :	Funera	1 Home
<u>~</u>	P P P P P P P P P P P P P P P P P P P	3 1	1/12	1. 1 al	10 th		2	6160 Oxon				D.2074	.5
П					lications/that cau ne cause on eac	sed the death. In line.	Do no	t enter the mode of dyin	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause disease or condition resulting in death)		a. V N	14000	•	Ditacho	~				Z Days
	Examiner				b	as a consequ	ence or,	J-					
-	p ti	mlner	Sequentially list co if any, leading to in	nmediate		as a conseque	ence of):					
	xecuted and al-transit	Exam	Cause (Disease or that initiated events resulting in death)	s 📲	c. Due to (or	as a conseque	ence of):				_	
68760,	death certificate be exec e attending physician an ed for use as the burial-tr			l	d								
9	rtificate ng phys as the	Medical	IF FEMALE:								77.		
Вох	eath certific attending p for use as 1	Physician/M	23b. Was deceden	it pragnant		ome of pregnan h 2 □ Fetal nt at time of de	death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	<i>y</i>		23	d. Date of de Month	livery Day Year
Q	by the de	nyslc	1 □ Yes 2 l 9 □ Unknown		9☐ Unknow		aun	3 Cities (specify)					
<u>а</u>	es that gned b					th but not resu	iting in t	the underlying cause gr	ven in Part I.			,	the cause of death?
ord	Screve April Stenosis									1]Yes 2. ☑	No 3∏Pi	robably 4 Unknown
Sec	Decodes the second of the seco									24a. We	topsy formed?	24b. Were at prior to death?	utopsy findings available completion of cause of
of Vital Records,			25 Was assa sata	read to madical					OS Place of Dog	1 🗹 Yes	2 No	1 🖺 Yes	2 □ No
Ę	Physicien: r this certificatal director.	To Be	25. Was case refe examiner? 1 ☐ Yes 2 ☑		Hospital: 1 Ing	patient 2 🗆 E	ER/Outp	patient 3□ DOA Ot	26. Place of Dea ner: 4 \(\sum \) Nursing H			Other (Spe	ecify)
	ding Phys h. After this funeral di		27. Manner of Dea	th 5 Pending	28a. Date of (Month,		28b. Tir Inj	me of 28c. Inju	ry at	28d. Describ			
Sio	tendii death. tor: A the fu	catle	2 Accident	investigation		f taiun. At ha	faw		Yes 2□No	28f Location	(Street and	Number or P	ural Route Number,
Division	I or Attendi after death. Director: A I in by the fu	Certification:	4 Homicide	determined	288. Place 0	g, etc. (Specify	me, iarr	n, street, factory, office			own, State)	realinger or n	urar noute Number,
	Hospitel or Attending 24 hours after death. Funeral Director: After tiely filled in by the fune		29a. Certifier (Check only					death occurred at the ti					
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one)		and manne	er stated.	or allu	or investigation, in my		ou at tile till			th, Day, Year)
	To To		29b. Signature and	elleto i	OW				777				7, 2005
	(0)		30. Name and add	lress of person who	completed cause	of death (Item	23a) (T	(ype, Print)	Δ. Δ.	1 /			
_ \								Type, Print) Tip Dove	Olney, in	crylend	2053		
		ate rar	31. Date filed (Mo	n <i>th, Day, Year)</i> N 0 4 2006	2. Re	gistrar's Signat	ure	Cart 1					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Van H. Edwards 19, 2005 December 14:30 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George Clinton Southern Maryland Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F 74 Yrs. 232-44-3539 West Virginia Director 1931 6. Usual Residence of Decedent deeth with the Maryland 10c. City Town or Location 10a State 10b. County 10d. Inside City Limits r then "natural", or Iteme 23a or 28a-f ehow the Medical Examinar must be notified at Oxon Hill 1 X Yes 2 No Director Maryland Prince George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20745 1410 Iverson Street United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No 195 If Yes, Give Year or Dates: 195 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1951filed within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black 1958 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 end 2 should be f Health and Mental I Henry Edwards Mamie Galson ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 i 1410 Iverson St., Oxon Hill, MD. Carrie Edwards/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State permit. Pages Depertment of I Importent: if its eny injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 5, 2006 Arlington, VA. 4 □ Donation 5 □ Other (Specify) Arlington National Pope Funeral Homes 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5538 Marlboro Pike Forestville, MD. 20741 23a. Part1. Enter the dis as or complications that caused the shock, or heart failur. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dving, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) Hente Myocarcha Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner anding physicien and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical ed by the ettending property detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ been signated 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b 24a. Was an autopsy performed 2 No 1 Tes 2 (1) No 1 Tes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 00A Alter this funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No investigation Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title/in Constition within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) D0055120 al mi) Dec 20 Lors 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Palner mo Just 310 Washington 1328 Jouthern avenue SE 31. Date filed (Month, Day, Year) . Registrar's Signature State **JAN 0 4** 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 1

			For State Registrar	State	of Maryla	-	artment of H		and Men		ene () ()5	436	94
			1. Decedent's Name (First, Middle,	Last)					2. [Date of Death		Voss	3. Time of	Death
	Physici: /Medic		John Woodrow E	den, Sr.					De	Month ecember	· 26, 2	2005	3:10	Рм
	Examin		4a. Facility Name (If not institution,	give street and no	ımber)		4b. City, Town, or	r Location o	of Death		4c. County			
			Crofton Convale				Crofton		0711		Anne			
	Funeral Director		5. Social Security Number 409–16–3922	5. Sex 1 X M 2 ☐ F	7. Age (In yr 86	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. [Date of Birth Month, Day, 1 -12–191	9 (9ar)	Cour	place (State or ntry) NESSEE	r Foreign
	pu s	-	Usual Residence of Decedent 10a, State 10b, County		10c	City, Town or Lo	ocation						IOd. Inside Cit	by Limite
	fanyla ethor	ត			100.	-						,	1 X Yes	-
	28a-1	Directo	Maryland Anne 7 10e. Street and Number	rundel		Annap	OLIS 10f. Zip Code			10	g. Citizen of V	What Cour	ntov?	
	with 3a or		10 Greystone Ct.	Unit .	Г		214	103			USA		, .	
	death with the Maryland ms 23a or 28a-f ehow rmust be notified at	Funerai	11. Marital Status	12. Was De	edent Ever in	U.S. 13.	Was Decedent of H		gin? (Specify	Yes or No-	14. Rac	e - Americ	can Indian,	
٥	or its		1 ☐ Never Married 2 ☐ Marrie	Armed F	2 🗆 No	ļ	it Yes, specify Cuba 1 ☐ Yes 2 ☐ X No	an, Mexican Specify:	, Puerto Hica	n, etc.)	1	k, White,		
215-0036	ed within 72 hours a giene. er than "natural", d "I'm Medical Exer	d by	3 X Widowed 4 □ Divorced	Year or	Dates: 194	2-47						Whi		
7	n 72 h	Completed	15. Decedent's (Specify only highest	s Education grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	durina most	t of working	11	6b. Kind of Bu	usiness/In	dustry	
_	within 72 ene. than "na	g .	Elementary/Secondary (0-12)	College 5+	(1-4or 5+)		mical Enc	,	-		Synthe	tic '	Textile	es
7 0	\$ £ £ £		17. Father's Name (First, Middle, L			_ Cile	micai mic			rst, Middle, M			101011	
Maryland 2	lid be lental ked c	To Be	Alic	Eden					Myrt	:le	Ang	gel		
a _Z	should and Men s marke umatic	7	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Maili	ng Address (Street	and Numbe	er or Rural Ro	ute Number,	City or Town,	State, Zip	Code)	
	l end 2 lealth a im 27 is		James L. Eden/ S	Son			ranklin S	Street	East	t Mills	stone,	NJ 0	8875-2	051
altimore,	Se of to		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from		. Place of Dispo cemetery, crea	osition (Name of matory or other place		Date		Oc. Location -	•		
Ē	Pages Iment of tant: if it jury or o		4 □ Donation 5 □ Other (Sp	ecify)	K		ematory	1	2-30-0		Edgewat			
Ba	permit. Page Depertment: Important: fi any Injury o		21. Signal ry of Juneral Service	Icensee			2. Name and Addre							
,	Physician		23a. Part 1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition	only one cause on	caused the de each line.		ter the mode of dyir			spiratory arres	st,	/	Approximate Interval Betwonset and D	ween Death
	/Medical Examiner		resulting in death)	Due to	(or as a cons	equence of):			_					
		10	Sequentially list conditions,	b. Due to	LMC	ATIQ						1	yeu m	lears
	of the state of th	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Fai	lure	t +	hrive							anth
,	icate be executed physicien and s the burial-transit	Exa	that initiated events resulting in death) Last	Due to	(or as a cons	equence of):						- (9000	-00(/0.
8760	te be ysicie	dicai		d.										
9	rtifica ng ph as th	Med	IF FEMALE:	I								1		
P.O. Box	The law requires that the death certificate be executed ste has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live	utcome of preo birth 2 Fignant at time of nown	etal death 3	□Ectopic pregnancy □ Other (specify) _	/				te of delive		/ear
	that	by Ph	Part II. Other significant condition	ns contributing to	death but not a	esulting in the u	inderlying cause giv	ren in Part I.		23e. Did toba	cco use cont	ribute to t	he cause of de	eath?
g	quires n sign	d b								1 🗆 Yes	2 X No	3 🗆 Prot	oably 4 🗆 U	Inknown
00	aw require s been sig 2 should t	Completed								24a. Was an	24b.	Were auto	psy findings a	available
æ	The lav	E								autopsy perform 1 Yes 2	ed?	prior to co death? 1 ∐ Yes	mpletion of ca 2 X No	luse of
<u>ra</u>		Bec	25. Was case referred to medical					26. Place	of Death (C)	heck only one		103	-10	
<u></u>	d in	10	examiner? 1 Yes 2 □ No			☐ ER/Outpatie		4 Nu	rsing Home	5 Residen	nce 6 □Oth	er (Specif	y)	
0	Attending Physician: or death. ector: After this certified by the funeral director, I		27. Manner of Death 1 Natural 5 ☐ Pending		of Injury nth, Day Year	28b. Time of Injury	Wor	y at k?	28d.	Describe how	v injury occur	red		
<u>s</u>	tendi leath. tor: A	cati	Accident investig 3 ☐ Suicide 6 ☐ Could n	ation ot be				Yes 2 1						
Division of Vital Records,	s after of all Directed in by	Certification:	4 Homicide determi	ned 286. Plac	ce of Injury - A ding, etc. <i>(Spe</i>	t home, tarm, st ecify)	reet, factory, office			Location (Stre City or Town,		er or Rura	al Route Numi	ber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medicai	29a. Certifier (Check only one) Medical E	xaminar: On the	ne best of my b basis of exam nner stated.	knowledge, deat ination and/or in	th occurred at the time time the time the time the time time the time time the time time the time time the time time the time time time the time time the time time time the time time time the time time time time time time time tim	me, date and opinion, deat	d place, and th occurred a	due to the car it the time, da	use(s) and ma te and place,	anner as s and due to	tated. the cause(s))
	To the within 24 To the F	×	29b. Signature and title of certifier	1_	-		29c. Licens	e number	19		d. Date signe			_
			30. Name and address of person wirza M. Nusain				n Center,	Suite	e 1, C					
	Sta		31. Date filed (Month, Day, Year)	32/	Registrar's Si	gnature								
Di	Regist		Seni () (.000		THE REAL PROPERTY.	and a							

DHMH 17 Rev 1/2001

		•	1 - For State Registrar	State of Marylan		artment of H		nd Men		iene 0 0	15	436	95
	Physici	an	1. Decedent's Name (First, Middle, La Leo John Eger	st)					Date of Deat Month	h Day	Year	3. Time of D	Death
	/Medic	al		a advantage of the second		4h Ciby Town or	Looption of		ecembe		2005	9:05	а м
	Examin	er	4a. Facility Name (If not institution, giv		. 1 /	4b. City, Town, or				4c. County			
	Funeral		15107 Interlacher 5. Social Security Number 6. S			Silver S If Under 1 Year	oring of Under 2	4 Hrs. 8.	Date of Birth	Mont	9. Birth	place (State or ntry)	Foreign
	Director		311-30-7853	☑ M 2□F 72	Yrs.	Months Days	Hours		(Month, Day, ec. 29,	1933	Indi	lana	
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation						10d. Inside City	v Limits
	f eho	ō										1 🗀 Yes	-
	r 28a	rec	Maryland Montgo	mery S	Silver	10f. Zip Code			1	0g. Citizen of W	Vhat Cou	ntry?	
	be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. do chter then "naturel", or items 23e or 28e-f ehow event, the Madical Examinal must be notified at	Funeral Directo	15107 Interlachen	Drive Apt. 8	14	20906				USA			
	r dea	ıner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origi n, Mexican,	in? (Specify Puerto Rica	Yes or No- an, etc.)	14. Race	e - Americk, White,	can Indian, etc.	
20	hours after turel', or ite al Examena	by F ₁	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 GYes 2 No If Yes, Give 195		1 ☐ Yes 2 ☑ No	Specify:			Specify			
3-003e	2 hour		15. Decedent's E	ducation	52 16a. Dece	dent's Usual Occupa	ation			16b. Kind of Bu		ite ndustry	
2 2	within 72 lene. then "nai he Medic	Completed	(Specify only highest grant Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most (')	of working				,	
A	fited wit Hygiene other the	Соп		4	Grant	s Adminis				U.S. G		nment	
	be fit ntal Hy od oth	0	17. Father's Name (First, Middle, Last)			18. Mother	's Name (Fi	irst, Middle, M	Maiden Sumam	ie)		
<u> </u>	d Mer narke	2	Leo M. Eger 19a. Informant's Name/Relationship	Time Reject	10h Maili	Address (Canada	Anna	N. 0'	Reilly	City - Town	C4-1- 7/	- 0- 4-1	
<u> </u>	id 2 sith an 27 to t					ng Address (Street a							906
စ်	permit. Pages 1 and 2 should be Department of Heath and Montal important: If item 27 is marked any injury or giber traumatic events.		Lucia A. Perez 20a. Method of Disposition		Place of Dispo	Interlac		rive ;	#814	Silver 20c. Location -	Spri City or T	ng MD own, State	
Ë	Page First of		1 ☑Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	THOMOVALITOM STATE	e of H	natory or other place eaven		on / '	2006	*1 C			1 1
altimore,	mit. partm porta y inju		21. Signature of Funeral Service Lice	nsee	22	Name and Address	s of Facility			ilver S	-	ig, Mary.	Land
ñ	88 5 8		2 compt	Juston (50	ancis J. O Univers	ity B	lvd.,	W.,Sil	nome, I ver Spr	nc. ing.	MD 2090	01
			23a. Part1. Boter the disease, or com shock, of heart failure. List only	plications that caused he deat one cause on each line.								Approximate Interval Betw	veen
	Physician		Immediate Cause (Final disease or condition resulting in death)	Congestive F	Heart I	ailure						Onset and Do	
	/Medical Examiner		1	Due to (or as a consec	quence of):							- **-	
	*** ****	e	Sequentially list conditions, if any, leading to immediate	b. Emphysema Due to (or as a consequence)								5 Years	
	outed Id ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Amiodarone-I	nduced	Lung Dis	sease				5	Years	
Ď,	sete be executed hysicien and the burial-transit	EX	resulting in death) Last	Due to (or as a conseq	quence of):								
9/8	certificete be executed ding physicien and use as the burial-transit	dlcal	•	d									
X	eath certific ettending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	ancy	-				23d Dat	te of deliv	1957	
Box	death	Iclar	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3	Ectopic pregnancy Other (specify)				Moi			ear
0	that the de led by the e detached t	hys	9 Unknown	9□ Unknown									
	8 200	by P	Part II. Other significant conditions	contributing to death but not res	sulting in the u	nderlying cause give	en in Part I.		23e. Did tob	pacco use contr	ribute to t	the cause of de	ath?
ord	w require been si should b	ted						_	1 🔯 Ye	s 2 No	3 Prol	bably 4 □Ur	nknown
Š	The law cate has b page 2 st	Completed							24a. Was a autops	V 1 C	prior to co	opsy findings at empletion of car	vailable use of
<u> </u>	sician: The certificate hi rector, page								perform	180? 2₩ No 1	death?	2 No	
Ĭ	nysician: nis certifica director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	FR/0	y 3 DOA Oth	or.		heck only on				
Division of Vital Records,	<u>a</u> = <u>a</u>	2	27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time o	" SU DOA	4 1 14013			ow injury occurr		(Y)	
Ö	uttending death. ctor: After y the funer	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		Injury		k? Yes 2 □ N	lo					
Σ	or Attended the death Director:	Certification:	3 Suicide 6 Could not to determined		ome, farm, st	reet, factory, office		28f.	Location (St City or Town	reet and Numb	er or Run	al Route Numb)O <i>r</i> ,
	urs of urs of sral D	S	A	1									
	To the Hospital or At within 24 hours effer of To the Funeral Directompletely filled in by	edical	29a. Certifier 1 Gertifying P (Check only one) 2 Hedical Exa	hysician: To the best of my kno miner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the time vestigation, in my of	ne, date and pinion, death	place, and hoccurred a	due to the ca at the time, d	ause(s) and ma ate and place, a	inner as s and due t	stated. to the cause(s)	
	vithin To the	Me	29b. Signature apolitile of certifier	- and marmor stated.		29c. License	e number		.5	9d. Date signed	d (Month,	Day, Year)	
,	5+1		N/ Smm			D60	0167		т	0211022	2 0	006	
1	3'/		30. Name and address of person who	completed cause of death (Item	m 23a) (Type,	Print)			J	anuary	5, 2	000	
	Feet 1		Michael N. Solomo		consin	Avenue	Chevy	Chase	, MD	20815			
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JAN 0 4	32/Registrar's Sign	ature de	artis							
	5762 JF 98			Vanda Maderia	-								

Laura Anne Fuller 05-08801 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. N.TM Unpend Items: 23tare27r Maryland / Debartinfenter Health and Mehral Hydrene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 28 Month **Physician** 2005 December Laura Ann Fuller 0930 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 7497 Madeline Drive Wicomico Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 44 Florida 262-65-4346 Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits worle rthan "natural", or Itema 23a or 28a-f ahov the Medical Examinar must be notified at 1 ☐ Yes 2X No Directo Wicomico Maryland Parsonsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7497 Madeline Circle 21849 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No ð Specify: Specify: 3 ☐ Widowed 4 X Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than College (1-4or 5+) Elementary/Secondary (0-12) Secretary Ceramics Gallery permit. Pages 1 and 2 should be lile Depertment of Heelth end Mental Hy Importent: If Item 27 is marked othn any liquy or other traumatic event. 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Jerald Callaway Martha Krais 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kielee Lewis/Daughter 7497 Madeline Circle, Parsonsburg, MD 21849 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hollywood Cemetery 1/2/2006 Harrington, Delaware 21. Signature of Juneral Service License Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Rd., Salisbury, enne part1. Enter the disease, or complication shock, or heart failure. List only one ex hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Methadone intoxication Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires thet the death certificate be executed physicien ar s the burial-t Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☑ Unknown Completed 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No autopsy performed 12 Yes 2 No Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA XIX Yes 2 □ No Other: 4 Nursing Home 5 Residence MAOther (Specify) Certification; To 28a. Date of Injury In 28b. Time of In 1-28c. Injury at (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred After s effer dec. ral Director: Afr 1 Natural 5 Pending 9:14 A.M 12/28/05 1 ☐ Yes 2X ☐ No investigation 2 Accident Unknown 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

FOUND at NOME 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7497 Maleline Driv 4 | Homicide filled in the Hospital Parsonsburg, Md. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the Hosp within 24 ho To the Fund completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME December, 29, 2005 0 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

20 5 Regist r's Signature

20 III Penn Street

Baltimore, Maryland 21201

			1 - For State Registrar	State of Maryland		artment of F rtificate of			Reg. No.	43697
	Physici	20	1. Decedent's Name (First, Middle, La					2. Date of De. Month	Day Y	3. Time of Death
	/Medic		CURMITH	GRAHA	M			12 - 31	-2005	8:43 p ^M
	Examir	ıer	4a. Facility Name (If not institution, gi	· ·			or Location of Death		4c. County of	
(S)	*** **********************************		5. Social Security Number 6.		et hirthday)	CLINTO	If Under 24 Hrs.	9 Date of Bird		GEORGES
10	Funeral Director		577-86-6930	Sex 7. Age (In yrs. Ia	Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da 3 - 7 - 1		Birthplace (State or Foreign Country) AMAICA
	W.		Usual Residence of Decedent					3-7-1	331 J.	AMAICA
	arylan show	_	10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	8a-f	Director	MD P.G.	FT	. WAS	HINGTON	T			1 X Yes 2 □ No
	with the		10e. Street and Number	CHONE DRIVE		10f. Zip Code	,		10g. Citizen of Wha	•
	s 23	Funerai	9015 LITTLE	12. Was Decedent Ever in U.S	12	2074		ocifu Voc or No	U.S.	A . American Indian,
	tter d	Fun	1 Never Married Married	Armed Forces?	. 13.	If Yes, specify Cubi	lispanic Origin? (Spann, Mexican, Puerto	Rican, etc.)	Black,	White, etc.
036	er, o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	BLACK
215-0036	n 72 hours after death with the Maryland "neturel", or flema 23a or 28a-f show saftal Expraner must be position at	Completed	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	pation during most of work	ina	16b. Kind of Busin	ess/Industry
2	- 22	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)			
CA	be filed within tal Hygiene. d other then event, the M.		17. Father's Name (First, Middle, Las	1		SUPERV				GROVE HOSP.
Maryland	ould be fi Mental H arked of	Be	SOLOMON	GRAHAI	νī		LELA	a (FIFSI, MIDDIE,	Maiden Sumame) PATIT	
Z	s 1 and 2 should be f f Health and Mental P Item 27 is marked of other traumatic ever	2	19a. Informant's Name/Relationship			ng Address (Street		al Route Numbe		nte, Zip Code 2 0 7 4 4
∑	ith ar lith ar 27 is r trau		LINDA W. GRAH							INGTON, MD
ē,	s 1 and if Health Item 27 other tr		20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name of matory or other place		Date .	20c. Location - Cit	
E	Page ent o nt: If ry or		1 ☐ Burial 2 XX Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	THemoval from State	-	LE CREM		9/06	RIVERDAI	LE, MARYLAND
Baltimore,	permit. Pag Department Important: eny Injury once.		21. Signature of Funeral Service Lice	ensee	22	2. Name and Addre	ess of Facility T		S FUNERA	
8	8972		1/3.6.	ulol	17	22 NORT	H CAPITO	OL ST.	, NW WAS	SH. DC 20001
10			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the death.	. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	alut	エス	Trace	uBral yTins	STR	oke	Onset and Death
16	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):	11		\$		2
E .	- Adminici		Sequentially list conditions,	b. Due to (or as a consequence	un	Hype	4/ms	00		flor flowers
	led sit	nine.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	erice or).					
	be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence	ence of):					
8760,	death certificate be executed e attending physicien and nd for use as the burial-transit		(d						
9	ifficati g phy as the	Physician/Medical		×						
Вох	death certifica attending ph d for use as th	J/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan		Ectopic pregnancy	,		23d. Date o	f delivery
	deat de att	sicie	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of de		Other (specify)	, 		Month	Day Year
P.0	that the de led by the a detached t	Phy	9 Unknown							
	90 Pe	by	Part II. Other significant conditions	contributing to death but not resul	lting in the u	nderlying cause giv	ren in Part I.		_	ite to the cause of death?
oro	w requir been si should	eted						, , ,	Yes 2□No 3[Probably 4 Alphnown
Records,	has b	Completed						24a. Was autop	osy _ prio	e autopsy findings available to completion of cause of
_								1 ☐ Yes	rmed? dea 2 1 □	Yes 2 No
Vital	Physician: this certific ral director.	Be	25. Was case referred to predical examiner?	Hospital:		t all post Oth	26. Place of Death			
ō	Phys r this ral di	1. To	1 Yes 2 Nanner of Death	28a. Date of Injury	PVOutpatier 28b. Time of	IL 3E DOX	4 Ivursing no		dence 6 Other (Specify)
Division	Attending I r death. ector: After by the funer	ţ	1 □ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	Injury	f 28c. Injur Wor M 1	rk? Yes 2 □ No		,,	
Visi	l or Attendir efter death. Director: Al I in by the fu	ifica	3 ☐ Suicide 6 ☐ Could not determined	286. Place of Injury - At nor	ne, farm, str	eet, factory, office		28f. Location (S	Street and Number of	or Rural Route Number,
ā	s efte	Certification:	4 Homicide	building, etc. (Specify)	,			City or Tov	vn, State)	
	hour hour uner		29a. Certifier 1 Descriping P	hysician: To the best of my know miner: On the basis of examinati	vledge, deatl	occurred at the tir	ne, date and place,	and due to the	cause(s) and manne	er as stated.
	To the Hospital or Attending Physician: Within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director.	Aedical	0110)	and manner stated.	on and/or in					
	Twitt of property of the prope	Σ	29b. Signature and title of confiner)		29c. Licens			29d. Date signed (A	
,	(1)		- HXX	21		1201	154		Janus	1,2,06
_ (4		30. Na and address of sin wh	Charge in Au	2	Print)	lua coa	2.00 m	2000)
	Sta	to	31. Date filed (Month), Day, Year)	32. Registrar's Signatu	ure >	-(1 3/	I ME J Z DE	-110 m	5 2070	2,2,06
	Regist	A 77 LA	JAN 0 4 200	Steel &	Anon	Re Comment		•		

			1 - For State Registrar	State of	Marylar				ealth a Death	and M		Reg. No		5	436	98
	Physici	an	Decedent's Name (First, Middle, Last								2. Date of De. Month	Day	y	Year	3. Time	
	/Medic	al	Ernest Eug		uy har		4b Cib	Town or	Location of	of Dogsth	Decembe	_		of Death		0 A ^M
4	Examin	er	Shady Grove Adv			1	4b. City		ville			40.				
	Funeral		5. Social Security Number 6. S	ex	7. Age (In yrs.	last birthday)		r 1 Year	If Under	24 Hrs.	8. Date of Birt	th		9. Birth	mery place (State	or Foreign
Ţ,	Director		415-36-014/	X M 2□ F		83 Yrs.	Months	Days	Hours	Min.	Jan. 12	,192	2	Tenr	iessee	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation								10d. Inside (City Limits
	Maryll	tor	MD Freder	ick		. Airy										s 2 X No
	r 28a	Director	10e. Street and Number				10f. Z	p Code		-		10g. Cit	izen of V	Vhat Cou	ntry?	
	th with	aiD	1902 S. Main	St.				217	71				U.S.	Α.		
	tems tems	Funerai	11. Marital Status	12. Was Dece Armed For	ces?	J.S. 13.	Was Dece If Yes, spe	edent of Hi	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	-		e - Ameri k, White	can Indian, etc.	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Give Year or Da	9	1	1□ Yes		Specify:				Specify	. Wh	ite	
9	be filed within 72 hours after death with the Maryland hal Hygiene. id other then "naturel", or items 23e or 28e-f show event, Ire Medical Expriner must be notified at	ted t	15. Decedent's Ed	ducation	163.	16a. Dece	dent's Usi	al Occupa	ation	-		16b. K	ind of Bu	siness/Ir		
212	hin 7:	pie	(Specify only highest gra Elementary/Secondary (0-12)	College (1-	4or 5+)				<i>furing</i> mos	t of worki	ng					
7	ygien ygien t, Es	Be Completed	6			Lands	cape	<u> </u>						ping	Co.	
aug	od off	Be	17. Father's Name (First, Middle, Last) Onnie Guy								<i>(First, Middl</i> e, / Egger:		Sumam	10)		
aftimore, Maryland 21215-0036	thould ad Me mark matic	မ	19a. Informant's Name/Relationship (Type, Print)		19h Maili	na Addres	s (Street a			Il Route Numbe		r Town	State 7i	n Codel	
S	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel; or Itema 23a or 28a-f show appringury or other treumatic event, Ita Medical Examination at an ance.		Mabel C. Guy - w								Airy,				0000)	
S.	of Head		20a. Method of Disposition 1 Ø Burial 2 ☐ Cremation 3 ☐	IR-a-val from 6		Place of Dispo	osition (Na	me of other place	e)	Г	ate	20c. Lo	ocation -	City or T	own, State	
Ĕ	Pagement ant: fl		4 Donation 5 Other (Specif			sthave	n Mer	n. Ga	rd. 1		.006					
Balt	ermit.		21. Signature of Furieral Service Licer	1500	hin						tzler I					
	an z e a		23a. Part T. Enter the disease, or com	COLO STREET	way						Liberty		n, M	D 21	762 Approxima	
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on ea	os i s		ter the mo	de or dynn	y, 30011 43	Cardiac	or respiratory at	11631,			Interval Be Onset and 2 day	tween Death
П	/Medical Examiner		Toolaing in dolling		or as a consec eumon i a										2 day	15
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	b	or as a consec							-			2 44	, 3
	cate be executed oblysician and the burial-transit	Examiner	that initiated events	C.												
Ö,	e exe cian a urial-t	I Ex	resulting in death) Last	Due to (or as a consec	quence of):										
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	•	d												
9 x	that the death certific ed by the attending p detached for use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	ome of pregn	ancy							23d Dat	e of deliv	2004	
Box	death e atter d for u	iciar	in the past 12 months?	4☐Pregna	nth 2 ☐ Feta ant at time of o		∃Ectopic p ∃ Other (s						Mo		Day	Year
P.O.	at the by the	hys	9 □ Unknown	9□ Unkno												
	w requires that been signed to should be deta	ρ	Part II. Other significant conditions of Non-Hodgki		ath but not re: homa	sulting in the u	ınderlying	cause give	en in Part I.						he cause of	
ord	requi	Completed	Non nougkt	по сущ	noma						101	Yes 2.	⊠ No	3 Pro	bably 4]Unknown
ဒ္ဌင	has t	mpl									24a. Was autop		1 0	Were auto prior to co death?	opsy finding: impletion of	s available cause of
e	n; Th ficate or, pag	င္ပ	25. Was case referred to medical								1 Yes	2 XNo		Yes	2 No	
⋚	ysicia s cert directe	To B	examiner?	Hospital:	npatient 2	ER/Outpaties	nt 3 🗆 D	OA Othe	_		n <i>(Check only c</i> me 5 ☐ R esid		€ □Oth	or /Saac	4.1	
20	og Ph ter th		27. Manner of Death 1 ☑ Matural 5 ☐ Pending	l	f Injury h, Day Year)	28b. Time o		28c. Injury Work			28d. Describe				19/	
Sioi	ttendir death. ctor: Af y the fu	catic	2 Accident investigation	n			М	1 🗆 '	Yes 2	No						
Division of Vital Records,	rs after d al Direct ed in by	Certification:	3 Suicide 6 Could not b 4 Homicide determined	288. Place	of Injury - At h ig, etc. <i>(Speci</i>	nome, farm, st ify)	reet, facto	ry, office			28f. Location (S City or Tox	Street ar wn, State	id Numb	er or Run	al Route Nu	mber,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 1 X Certifying Ph 2 Medical Exam	nysician: To the miner: On the ba and mane	sis <u>of e</u> xamin	owledge, deat ation and/or in	th occurred vestigatio	d at the time n, in my or	ne, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s date and	and ma d place,	nner as s and due t	stated. o the cause	(s)
	To the P within 2- To the P complete	Σ	29b. Signature and title of certifier	1				c. License	number			29d. Da	te signe	d (Month,	Day, Year)	
	WIL		トレレレスで		KURU	/			04618	7		Dec	. 29	9, 20	005	
	4		30. Name and address of person who Ajit P. Kuruvi					#208	3, R	ockv	ille. M	D 20	852			
V Sec	Sta	ite	31. Date filed (Month, Day, Year)	32. Re	ortrar's Sign	ature					- , • •					
	Regist	rar	JAN 0 4	2006	Book is .	K	Kan	2.								

			State of Ma State Registrar/VEND#26penMD1/4/06, BWW, Mo	aryland / Depa	rtment of Health and Mitificate of Death	lental Hygier	1000	43699
	Physici /Medic		1. Decedent's Name (First, Middle, Last) A aron H. Gold star				Day Year	3. Time of Death
	Examir Funeral Director	er.	4a. Facility Name (If not institution, give street and number) 316 Priest Ford Read 5. Social Security Number 6. Sex 1 M M 2 F 7. Age	e (In yrs. last birthday) 92 Yrs.	4b. City, Town, or Location of Death Church ville If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		4c. County of Death Her for 9. Birth ar) 1913 New	pplace (State or Forei
			Usual Residence of Decedent 10a. State 10b. County Maryland Montgomery	10c. City, Town or Loc Silver		octobel 16	,1919 New	10f K, IV.
	with the M 3a or 28a-f	Funeral Director	10e. Street and Number 702 Gist Avenue		10f. Zip Code 20910		Citizen of What Cou United St	untry?
980	72 hours after death with the Maryland natural', or items 23a or 28a-f show ilical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Amed Forces? 1 X Yes 2 Never Married If Yes, Give Year or Dates:	No	Vas Decedent of Hispanic Origin? (Sp. Yas, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify:	
21215-0036	within ane. than	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	16a. Deced (Give I life. D	ent's Usual Occupation kind of work done during most of work OO NOT use retired) iatric Social Wor	king	Kind of Business/li ederal Go	
Maryland	should be filed of Mental Hygis marked other imatic event, the	To Be (dstein	Rebecca		Yetnikoff	
	s 1 and 2 s if Health ar item 27 Is other treu		19a. Informant's Name/Relationship (Type, Print) Alan Goldstein -son 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State	702 G	natory or other place)	Spring, N	Maryland . Location - City or T	20910 Town, State
Baltimore,	permit. Page Department o Importent: If any injury or once.		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee **Devolation U.B.*** **Property of the service Licensee** **Prop	a D8	d Memorial Garder naTdndvddeBotgwardt OO Powder Mill ko	Funeral F	Home, PA	
8760,	Physician / Medical Examiner the prital-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease our injury that initiated events C	a consequence of):		or respiratory arrest,		Approximate Interval Between Onset and Death
Box 6	death certifi e attending I id for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetel death 3	Ectopic pregnancy Other (specify)		23d. Date of deliving Month	very Day Year
ords, P.O.	w requires that the de been signed by the s should be detached to	ed by Ph	Part II. Other significant conditions contributing to death b Rene! Insulations	ut not resulting in the un	iderlying cause given in Part I.			the cause of death?
of Vital Records,	The law ate has b page 2 sf	e Complet	Conseshin Heart failure Alzhei mer's disease 25. Was case referred to medical		OF Disco of Days	24a. Was an autopsy performed 1 Yes 2 1	death?	opsy findings availab ompletion of cause of 2010
Division of Vi	Attending Physician: r death. actor: After this certific by the funeral director,	Certification; To B	examiner? 1	ry 28b. Time of	t 3 DOA Cther 4 Nursing Ho 28c. Injury at Work? 1 Yes 2 No	/ G2	jury occurred	
Div	Hospital or Atten A hours after deat Funeral Director: elely filled in by the		4 Homicide determined 28e. Place of Injudicing, etc. 29a. Certifier (Check only 2 Medical Exeminer: On the basis of	c. (Specify) of my knowledge, death	occurred at the time, date and place	City or Town, Sta	ate)	stated
	To the h within 24 To the F complete	Medical	one) and manner sta 29b. Signature and title of certifier	ated.	29c. License number		Date signed (Month,	
	(D		30. Name and addre s of person who impleted cause of d	leath (Item 23a) (Type, I	D 31295		12/28/05	
	Sta R egist		Wende Kloesz mp 50 31. Date filed (Month, Day, Year) JAN 04 2006	ar's Signature	Print) Raven Tolud Pob	Suik 7081	4 Balt,	md 21239

DHMH 17 Rev 1/2001

			for State Registrar	State	of Marylar			t of He e of D		nd Me	ental F	lygie Reg		5	43	700
	Physici	4 20	1. Decedent's Name (First, Middle, La.	st)							2. Date of Month	Death	Day	Year		e of Death
	Physici /Medic	_	Mintie E. Glass								Decen	nber	31,	2005	9:2	0 а м
	Examin	er	4a. Facility Name (If not institution, give	e street and n	um <i>ber)</i>		4b. City,	Town, or L	ocation of	Death			4c. County	of Death		
L.	*	7 m	Suburban Hospita				Be If Under	thes	la If Under 2	4 Use	0.00	D	Mon.	tgome		
	Funeral		5. Social Security Number 6. S	ex □M 2[X F	7. Age (In yrs.	79 Yrs.	Months		Hours	Min.	8. Date of (Month,	Day, Y				te or Foreign
	Director		165-22-7693 Usual Residence of Decedent			79					Nov.	/,	1926	Peni	ısylv	anıa
	land ow		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation								10d. Inside	a City Limits
	Man Feb	to	Maryland Montgo	merv	7	Bethesd	а								1 🗆 🗅	res 2 xNo
	r 28e	Director	10e. Street and Number			30011000	10f. Zip	Code				10g	. Citîzen of V	Vhal Cou	ntry?	
	1) wit	O E	9926 Brixton Lan	e			20	0817					US.	A		
	deel me	Funeral	11. Marital Status	12. Was De	cedent Ever in U		Nas Deced	dent of Hisp	panic Origi	in? (Spec	orty Yes or	No-		e - Ameri k, White,	can Indian	١,
õ	hours after deeth with the Maryland turel', or Items 23e or 28e-f ehow at Exoniner roast be notified at		1 Never Married 2 Married		2 ∑ No		1 🗆 Yes		Specify:		, 5.0.,			White		
3	urel',	d by	3 Widowed 4 Divorced	Year or	Dates:											
212-0030	nati	iete	15. Decedent's E (Specify only highest gra	ducation a <i>d</i> e co <i>mplete</i> c	d)	16a. Deced	ient's Usua kind of wo DO NOT us	rk done du	ion ring most i	of workin	g	16	b. Kind of B	usiness/In	dustry	
7 7	within in the new in the Man	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+) 5+								Educa	a+ i ax		
	be filed within 72 hours after deeth with the Marylan ital Hygiene. ed other then "naturel", or items 23s or 28s-1 show of other then "naturel", or items 23s or 28s-1 show event, the Madical Examiner mast be notified at	ပိ	17. Father's Name (First, Middle, Last)	<u> </u>	ALC	Teac		8. Mother	's Name	(First, Mid	dle, Ma	iden Suman		1	
ā	d be ental	o Be	Robert F. Eberha						Pear	1 He	rndor	1				
maryland	should be filed vind Mental Hygie s marked other i umatic event, IL	-	19a. Informant's Name/Relationship (19b. Mailir	ng Address	(Street an	id Number	or Rural	Route Nu	m <i>b</i> er, C	City or Town,	State, Zij	Code)	
Ž	nd 2 aith a 27 is r trau		Park Roy Glass,	Jr./Hu	.sband	9926	Brixt	on L	ane,	Beth	esda,	, Ma	rylan	d 208	317	
ē,	f Height		20a. Method of Disposition			Place of Dispo cemetery, crer	sition (Nar	ne of	1	Jar	i. 10,	20	c. Location -	City or T	own, Slate	9
Ē	Page # 50		P☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			Lington N				2	006	Ar	lingte	on, V	/irgi	nia
Baitimore,	permit. Pages 1 end 2 should be Department of Health and Menta Importent: if item 27 is marked any injury grother traumatic e anges.		21. Signature of Funeral Service Lice	nsee		$\mathbf{F}_{\mathbf{I}}^{22}$	avarea	ad Address	C6F19lity	ns F	unera	al H	Home I	nc		
n	88 = 8		James 9	Doch.	Par	50	0 Uni	ivers	ity B	Blvd,	W, S	Silv	Home In	ring,	MD	20901
	4		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that	t caused the dea	th. Do not ent	er the mod	e of dying,	such as c	ardiac or	respirator	y arres	t,			Between
	Physician		Immediate Cause (Final disease or condition		Selsi	<									Onset a	and Death
14th 1	/Medical		resulting in death)	Due t	to (or as a conse	quence of):							· · · · · ·			/2
#	Examiner		Sequentiatly list conditions,	b		1400	1 4								10	lays
	p is	iner	rt any, leading to immediate cause. Enter Underlying	Due t	to (or as a conse	quence of):								ŀ	Λ	
	and I-tran	Examine	Cause (Disease or initury that initiated events resulting in death) Last	c	o (or as a conse	o FC				-					d	verk)
8760,	reate be executed physicien and s the burial-transit	a E			.0 (01 40 4 001.00	4001100 01).										
287	E P E	dical	13.	_ d												
×	death certific e ettending p ed for use as	/We	IF FEMALE: 23b. Was decedent pregnant		oulcome of pregr								23d. Da	te of deliv	erv	
ROX	etter d for u	Physician/M	in the past 12 months?		e birth 2 ☐ Fet ignant at time of		Ectopic p							onth	Day	Year
P.O.	the c	hysi	9 Unknown	9 Uni	known						_					
	uires thet the dea	by P	Part ti. Other significant conditions	contributing to	death but not re	sulting in the u	nderlying o	ause giver	n in Part I.		23e. D	id toba	cco use cont	tribute to t	he cause	of death?
ğ	w require been sig should b										1	☐ Yes	2/No	3 ☐ Pro	bably 4	□Unknown
000	law requires thet the es been signed by th 2 should be detache	Completed									24a. V	Vas an utopsy	24b.	Were auto	opsy findi	ngs available of cause of
Ě	The ste h	E O									p 1□ Ye	erforme	No.	death? 1 ☐ Yes		or cause or
Division of Vital Records,	Physician: The lav this certificete hes al director, page 2	Be	25. Was case referred to medical examiner?								(Check or	пу опв)				
<u>~</u>	Physic this co	2	1 ☐ Yes 2 No			ER/Outpatie		Other Other	4 🗆 Nur	sing Hon	ne 5□F	lesiden	ce 6 □Oth	er (Speci	fy)	
ū	Ing I	on:	27. Manner of Death 1	28a. Da (M	te of Injury onth, Day Year)	28b. Time o		28c. Injury Work?			8d. Descri	be how	injury occur	red		
S	Attend er death rector: A by the fi	cati	2 Accident investigation 3 Suicide 6 Could not to				М		es 2□N			10				
\leq	or All after of Direction by	Certification:	4 Homicide determined	288. Pla	ace of Injury - At I itding, etc. (Spec	nome, tarm, st cify)	reet, factor	y, office		2		Town,	et and Numb State)	oer or Hur	ai Houte i	Vum <i>ber</i> ,
_	pitel ours a erail filled		29a. Certifier	hveician: To	the best of my ke	nowledge deat	h occurred	at the time	data and	d place of	and due to	tha as-			-10104	
	24 h	Medicai	(Check only 2 Medical Exa	miner: On the	a basis of examin	nation and/or in	vestigation	ı, in my opi	nion, death	h occurre	d at the tir	ne, dati	e and place.	and due t	to the cau	se(s)
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Me	29b. Signature and title of certifier				29	c. License	number			290	d. Date signe	d (Month,	Day, Yea	ar)
•	5		Y A A	A .	~0			DS	665	2		D	Pen		4 1	1005
			30. Name and address of person who	completed ca	anner stated.	em 23a) (Type,	Print)						v v(~1 /		11	
_			Matthen pot	tenist	, MO	9901	Me.	lical	Cer	te.	0-ive		Rock	-1/4	M	٥
		ate	31. Date filed (Month, Day, Year)	300	Registrar's Sign	nature	and P					-				
	Regist	rar	JAN 04 2	JUD /	A CHARLES	- FI										

Glass, MINTE 12/31/05 OGOM

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 25, 2005 2:15 A M Thomas P. Herrell, Jr. December /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Edgewater 3856 PONDER DRIVE Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1X M 2□ F 579 20 4926 Director 80 JUNE 07, 1925 VIRGINIA Usual Residence of Decedent e filed within 72 hours effer death with the Marylend at Hygiene. other than "natural", or items 23a or 28-4-1-----10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location ir than "natural", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Directo MARYLAND ANNE ARUNDEL EDGEWATER 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3856 PONDER DRIVE UNITED STATES Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1943-46 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: WHITE Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed w Department of Heath and Mental Hygier Important: if Item 27 is marked other it any injury or other traumatic event, ILS ODG. 12 MANAGER WHOLESALE MEAT PURVEYOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ THOMAS PAUL HERRELL SR. DOROTHY GERTRUDE WASHBURN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TRACY'S LANDING MELISSA MONKELIEN (NIECE) 6349 GENCA ROAD MD. 20779 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) COLUMBIA GARDENS CEM. 12-28-05 ARLINGTON, VA. 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10state Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last iner Due to (or as a consequence of) certificate be executed burial-transit Exami and Due to (or as a consequence of): Box 68760, physicien Physician/Medica the **USB 85** IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) the (o detached 9 Unknown à ت signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, <u>۾</u> page 2 should be 2 200o 3 Probably 4 Unknown 1 Tes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an āw hes autopsy performed? The certificete 1 Yes Vital Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 No ဂ္ 2 ER/Outpatient 3□ DOA o this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Pescribe how injury occurred Certification; After Injury Division Matural 5 Pending spitel or Att.
4 hours after death
ners! Director: At 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Cond not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Duicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital c within 24 hours af To the Funeral D completely filled in Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D58166 05 30. N e and address of person who completed cause of death (Item 23a) (Type, Print) 3169 BRAVERTON ROAD SUITE 101 EDGEWATER, MD 21037 ERIC C. MARCALUS M.D. 2. Registrar's Signature State Registrar

			For State Registrar	State of Mary		partment of h <i>ertificate of</i>			ene 005	43702
	Obvoisi		1. Decedent's Name (First, Middle, Las	t)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		HOWARD O. HA	RDESTY, SR.				DECEMBER		8:15 P ^M
	Examin		4a. Facility Name (If not institution, give			_	r Location of Death	1	4c. County of Death	1
			3653 Muddy Creek		to a total	Edgewa			Anne Ar	
	Funeral Director		5. Social Security Number 6. Sec. 218–28–2409	0x 7. Age (# 0 M 2□F 83	oyrs. last birthd Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth	pplace (State or Foreign intry)
	D		Usual Residence of Decedent					JUNE 27,	1922 Mary	Tand
	how		10a. State 10b. County	_	c. City, Town o					10d. In side City Limits
	8a-1 a	Funeral Director	Maryland Anne Aru	ındel	E	dgewater				1 ☐ Yes 2 ☐ X No
	vith th		10e. Street and Number			10f. Zip Code		100	g. Citizen of What Cou	intry?
	8 23s	ral	3653 Muddy Creek			21037		- 4 V	USA	
	iter de	Š	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Eve Armed Forces? 1 ☑ Yes 2 ☐ No	rin U.S.	 Was Decedent of F If Yes, specify Cub 	an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
99	urs at	٥	3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 19	14_46	1 ☐ Yes 2 No	Specify:		Specify: Wh	ite
5-0036	filed within 72 hours after death with the Maryland Hygiene ther then "natural", or items 23a or 28s-f ahow ther then "satural" or items and it it Madical Examination of the confiled at	Completed	15. Decedent's Ed	ucation	16a. De	cedent's Usual Occup ive kind of work done	pation	king 16	6b. Kind of Business/I	ndustry
7	iffhin a	du	Elementary/Secondary (0-12)	College (1-4or 5+)	lif	DO NOT use retire	d)	n'''y	_	
2	led w lygier her th	ပိ	6th		Tru	ck Driver			Fuel	
Maryland 2121	ntal Hed of	Be	17. Father's Name (First, Middle, Last) Raymond Joseph	h Hardeety				ne <i>(First, Middle, Ma</i> 1 Daisy C	,	
Ž	thould Me Me Me Merk	2	19a. Informant's Name/Relationship (7		19h M	ailing Address /Street			City or Town, State, Z.	in Code)
ĕ	od 2 s lith ar 27 is r trau		Margaret E. Harde						r, MD 2103	
altimore,	f Hea f Hea item othe		20a. Method of Disposition	- 2	Ob. Place of Di	sposition (Name of crematory or other pla			oc. Location - City or 1	
Ë	Page nent o nt: if		1 SpBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	-	nville U.N		3-06 D	avidsonvil	le, MD
a	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene Important: if item 27 is marked other then "natural", or items 23a or 28a-f ahow amy njury or other traumatic event, the Madical Experient must be notified at an Once.		21. Signature of Funeral Service Licen						alas Funer	
<u> </u>	89 5 5 8		Wort of the	l-		2973 Solon	nons Isla	nd Rd. Ed	gewater, M	D 21037
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the one cause on each line.	death. Do not	enter the mode of dyi	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between
a	Physician		Immediate Cause (Final disease or condition	· Bespi	ralo	ry Fai	lure		b	Onset and Death
П	/Medical Examiner	1	resulting in death)	Due to (or as a co	onsequence of	y Fai 's Tin	- 1			
1		-	Sequentially list conditions	b. /// 2 / 4	nsequence of	's Ten	ren Ga			0 1100
	rted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			enter				10
Ć.	execunand and ial-tra	Exal	that initiated events resulting in death) Last	Due to (or as a co		eaca	1 S R a.			70 9 70 10.
68760,	licate be executed physician and s the burial-transit	edical		d				_		
		Jedi	IE SEMALE.							
Box	The law requires that the death certifute has been signed by the attending tage 2 should be detached for use a	Physician/M	230. Was decedent pregnant	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐		3 Ectopic pregnance	v		23d. Date of deli	
E	e dea the at hed fo	ls Ic	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time 9□Unknown		5 Other (specify)	,		Month	Day Year
P. 0.	hat th ad by detacl	문	Part II. Other significant conditions of	ontobuting to death but n	ot resulting in th	a underlying cause of	on in Part I	23e Did toba	acco use contribute to	the sauce of death?
ds,	signe d be	d by	Chronic A				ren in Fait i.			bably 4 Unknown
Š	v requ been shoul	Completed						-		
Be	he lay e has sge 2	E C						24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of
ta	ifficat or, pa	ပိ	25. Was case referred to medical				26 Place of Dee	th (Check only one)		2 No
\equiv	ysich is cer direct	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpa	tient 3 DOA Ott			ce 6 ☐Other (Spec	ify)
0	Attending Physician: sr death. ector: After this certifics by the funeral director, p		27. Manner of Death 1 SNatural 5 □ Pending	28a. Date of Injury (Month, Day Ye	28b. Tim	e of 28c. Injui	y at	28d. Describe how	injury occurred	-,,
Sio	eath. or: A	catle	2 ☐ Accident investigation				Yes 2 □ No			
Division of Vital Records,	i or Att after d Direct I in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5	At home, farm, Specify)	street, factory, office		28f. Location (Stre City or Town,	et and Number or Rui State)	ral Route Number,
	pitai ours a ierai f		29a. Certifier 1X Certifying Ph	veisien: To the best of m	u kaandadaa d	and have a second at the second				
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Examone)	ysician: To the best of m mer. On the basis of ex- and manner stated	amination and/o	r investigation, in my o	me, date and place opinion, death occu	, and due to the cau rred at the time, date	e and place, and due	stated. to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier			29c. Licens	se number	290	d. Date signed (Month	Day, Year)
			- TELSAN	7.5.		14 9	17499		12/30/	05
		1	30. Name and address of person who							
			Moriand				FORE	IT FR.	ANNA	POCIS
	Sta Regista		31. Date filed (Month, Day, Year)	2. Registrar's	Signature	and i				
	riegist	1.1		9	- 49					

		,	1 - For State Registrer	State of	Maryland		artment of H		d Mental Hy	gieņe Reg. No.	05	437	03
	Physici	an	1. Decedent's Name (First, Middle,	ast)					2. Date of De Month		-Year _	3. Time of	
	/Medi		Dorothy K. Hinma						Dec.	30	2005	5:15	Рм
	Examir	er	4a. Facility Name (If not institution, of The Annapolitan				4b. City, Town, or Annapol		Death		unty of Death • Arun	de1	
9	Funeral				7. Age (In yrs. las	t birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Bir	th	9 Birth	place (State ontry)	or Foreign
*	Director		220-03-2307	1 ☐ M 2 X F	84	Yrs.	Months Days	Hours	July 26	5, Year 92	1 Ohi		
	pu ≱ ∴		Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	Town or Lo	cation					10d. Inside Ci	itu Limita
	Maryli f eho	ō	Virginia Middle	sex .	1	anna							2X No
	r 28a-	Director	10e. Street and Number				10f. Zip Code			10g. Citizer	of What Cou	ntry?	
	th with	aiD	155 Perkins Wood	s Road			23175			Unit	ed Sta	tes	
36	be filed within 72 hours after death with the Maryland hat Hyglene. Id other than "natural", or Itams 23e or 28e-f show o'd other than "natural", or Itams 20e or 28e-f show event, the Madical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3/25/Widowed 4 Divorced	Armed For	2√3√ No e		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin in, Mexican, P Specify:	? (Specify Yes or No Puerto Rican, etc.)		Race - Americ Black, White, ecify: Wh	can Indian, etc. ite	
ğ	2 hou	ted	15. Decedent's	Education		16a. Dece	dent's Usual Occupa	ation		16b. Kind	of Business/In	dustry	
215	thin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	kind of work done of DO NOT use retired	during most of ()	working				
2	led wi		12			Ho	memaker				Home		
aryland 21215-0036	should be filed vand Mental Hygie marked other tumatic event, the	Be	17. Father's Name (First, Middle, La William Fenker	st)					Name (First, Middle, rine Webb	Maiden Su	mame)		
Ž	should Ind Men	၉	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street a		r Rural Route Numbe	er City or Tr	own State Zin	Code)	<u> </u>
≥	and 2 sealth ar n 27 is		David Hinman/ s						Annapoli:			700007	
altimore,	ss 1 and 2 should b of Health and Ment item 27 is marked r other traumatic e		20a. Method of Disposition			e of Dispo	sition (Name of natory or other plac	e)	Date	20c. Locat	ion - City or To	own, State	
Ĕ	Pages ment of ant: if its ury or o		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		tate		oln Crema		-3-2006	Brentv	wood, M	arylan	ıd
Balt	permit. Pages 1 Department of He Important: if iter any injury or oth		21. Signature of Funeral Service Lic	POMENS	lý				John M. T ester St.				
8760,	Physician pe executes the execute of the physician physicien and physicien action physician phys	dical Examiner	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, 1 at y, 1 and 1	a. Que to (c	or as a consequer	nea of):	Má					Interval Bett Onset and f	
O. Box 6	death certifi e attending d for use as	cian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Pho 9 ☐ Unknown	1☐Live bir	come of pregnancy th 2 Tetal de ant at time of deat	ath 3[Ectopic pregnancy Other (specify)			23d	. Date of delive Month	_	Year
٥.	hat th	by Phys	Part II. Other significant conditions	s contributing to de	ath but not resulting	on in the u	aderhina cause aive	an in Part I	23e Didt	obacco uso	contribute to the	an cause of d	loath?
Records,	uires tha signed I Id be det		•			·9 ·· · · · · ·	raony ing cause give	ariiri atti.		res 2□N			Unknown
Ö	The law requires that the tite has been signed by the page 2 should be detached.	Completed							24a. Was	an 2	4b. Were auto	psy findings a	available
	an: The law riflicate has for, page 2 :	mo							autop perfo	rmed?	prior to condeath?	mpletion of ca	ause of
Vital		BeC	25. Was case referred to medical					26. Place of	1 ☐ Yes Death (Check only o	2 No	1 🗌 Yes	2 No	
	Physician: this certific ral director,	To	examiner? 1 Tes 2 No	Hospital: 1 🗆 In	patient 2 ER	VOutpatien		4 🗀 Nursiii	ng Home 5 Resid	dence 6 5	ther (Specif	Assis	ted
Division of	9 9	ion:	27. Manner of Death 1 Natural 5 ☐ Pending		f Injury o, Day Year)	Bb. Time of Injury	Work		28d. Describe t			Livi	
<u>S</u>	Attending in death.	ficat	2 Accident investigat 3 Suicide 6 Could not	be One Blees	of Injury - At home	a farm str		Yes 2 □No	28f. Location (S	Street and N	umber or Pure	I Pauta Num	har
<u>></u>	after Dire	Certification:	4 Homicide determine	buildin	g, etc. (Specify)	s, iaiii, sii	eet, lactory, office		City or Tov	vn, State)	umber or Aura	ii noute ivumi	ger,
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: At completely filled in by the fur	edical C	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the I aminer: On the bas and manne	sis of examination	edge, death and/or inv	occurred at the time restigation, in my op	ie, date and pl pinion, death o	lace, and due to the occurred at the time,	cause(s) and date and pla	d manner as si	tated. the cause(s))
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. License			29d. Date si	gned (Month,	Day, Year)	
			Mh	MI	>		D 38	958		1/1	106		
			30. Name and address of person with	o completed cause	/	Ba) (Type,	Print)	4.1		0 0			
(Fe	Sta	to.	31. Date filled (Month, Day, Year)	L Scoth	gistrar's Signature	008	Crain 1	rag Leve	ay Siv G	lin Bi	ernie N	11) 210	6]
	Registr			2006	ane L	1	and s		~				

Amend #10 C Per FD 1-06-2006 A.A. Co. Health Dept. PM Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 2005 Year Gloria C. Hollywood Dec. 29, 6:45 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕱 E 81 Director 119-14-2145 Yrs. Dec. 16, 1924 NYUsual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Items 23e or 28e-f show treumatic event, the Medical Examiner must be notified at Arnold MD Anne Arundel Srnold Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with Innent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or Items 23e or it 453 Shore Acres Road, Apt. 1A 21012 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2X No 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **Home** 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Albert Cunningham Elizabeth Feeley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 513 Kegworth Court, Severna Park, MD Robert T. Hollywood/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of i Importent: if It any injury or o once. Dec. 31, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metro Crematory Baltimore, MD ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Funeral Service Licensee 495 Gov. Ritchie Hwy, Severna Park, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiogenic Shock
Due to (or as a consequence of): Physician disease or condition resulting in death) /Medical Examiner ardic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is its tool assets.) Examiner Due to (or as a consequence of): or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit been signed by the attending physicisn and should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

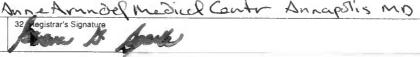
1 Yes 2 No
9 Unknown Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 314 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 1 No 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b Signature and title of control 29c. License number 29d. Date signed (Month, Day, Year) D80058297 29/05

State Registrar 31. Date filed (Month, Day, Year)

JAN 0 3 2006

ouse

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey Year December 29, 2005 **Physician** Maximo Herrera 8:10 a.m /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Randolph Hills Nursing Home Wheaton Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthdev) 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) **Funeral** Days Months Min. 1X M 2□ F Hours Director 99 213-56-9737 Argentina Usuel Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Merylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or items 23s or 28s-f shorthe Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Silver Spring 10e. Street end Number 10g. Citizen of What Country? 12101 Foley Street Funeral 20902 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 23☐3No If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ Specify 3 ☑ Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Hygiene. 9 Gardener Horticulture 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental marked Herrera Alejandra Cevallo and 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12101 Foley Street Silver Spring, Maryland Dora Matthews Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ò ertment ortant: If Injury o 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 22. Name and Address of Fecility Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service Licensee Colliny 500 University Blvd., W., Silver Spring, MD 20901 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical e Cardiac Arrest Examiner Due to (or as a consequence of): Examiner Coronary Artery Disease The law raquires that the death certificate be executed physiclen end the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or es e consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): anding ph foru P.0. Part II. Other significant conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No certificate has been signed I iractor, pege 2 should be dat Alzheimer's Disease Division of Vital Records, ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? TUYES ZIXING 1 ☐ Yes 2 ☐ No Attending Physician: Be diractor, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 1 Yes 2 🔀 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funerel 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending s aftar death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 9 To the Hospital of within 24 hours a To the Funeral D 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completaly 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) D 52261 agra lan December 30,2005 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) 1317 Hugo Circle Alan R. Segal, M.D. Silver Spring, Maryland 20906 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 04 2006 Registrar

DHMH 16 Rev 6/95

ADH , JASON ANTHONY INMAN 05-8701

701		-	- State Amend Item Registrar	State of Marylan 28f per ME,C8!	d / Depa 51,01/2	artment of 0.06dhb	Health an <i>Death</i>	d Mental Hy	giene 0 0	5 43706
	Physicia		1. Decedent's Name (First, Middle, La Jason A.					2. Date of De Month DECEME	0.	3. Time of Death 0313 a M
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town,	or Location of D		4c. County	of Death
			RT. 214 NEAR RT.		land hinth days	LARGO	If Under 24	Hrs. O Date of Bi		E GEORGES
	Funeral Director	- 1	5. Social Security Number 6. S 213-21-5491	7. Age (In yrs.	Yrs.	Months Days		Min (Month, Da	iv. Year)	9. Birthplace (State or Foreign Country) Washington, DC.
	and		Usual Residence of Decedent 10a, State 10b, County	10c. Ci	y, Town or Lo	cation				10d. Inside City Limits
	Maryli -f eho	to	Maryland Prince	George	Temp1	Hills				1⊠Yes 2 No
	ith the	Directo	10e. Street and Number			10f. Zip Code	207/9		10g. Citizen of W	-
	leath v	Funeral	2013 Chita Cour	12. Was Decedent Ever in U	.S. 13.1	Was Decedent of	20748 Hispanic Origin	n? (Specify Yes or No Puerto Rican, etc.)		a - American Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show eny injury or other traumatic event, Ita Medical Examinar must be contified at angle.		1 ★ Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		if Yes, specify Cul 1 ☐ Yes 2☑ No		Puerto Rican, etc.)		k, White, etc. Black
5-0	72 ho "natur	eted	15. Decedent's E (Specify only highest gr.	ducation ade completed)	16a. Dece	dent's Usual Occu kind of work done DO NOT use retir	pation during most of	f working	16b. Kind of Bu	siness/Industry
2121	l within piene. r then	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	1	fied Ele			Priva	ite
Maryland 21215-0036	be filed tal Hyg d other	Be C	17. Father's Name (First, Middle, Last)				Name (First, Middle		θ)
ryla	hould I d Meni marke matic	ဍ	Dwayne Inman 19a. Informant's Name/Relationship (Type Print)	19b Mailir	on Address (Stree	1	nna C. Gla or Rural Route Numb		State, Zin Code)
Ma	alth an 27 le sr trau		Donna Inman Moss/					Bowie, MD.		
Baltimore,	ges 1 st of He If item or other		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crei	sition (Name of matory or other pl	,	Date		City or Town, State
Itim	artmen ortant: Injury		4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Service Lice		2	[emorial 2. Name and Add		2. 31, 2005 Pope Fur	Suitla neral Hom	
Ba	Depa Impo eny Ir		1 avo	Whell	<i>A</i>			5538 Mar Forestvi	lboro Pi lle, MD	ike 20747
4	Physician /Medical Examiner	ər	23a. Part1. Enter the disease of conshock, or heart faiture List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, havy leading to annualistu.	a. Muth Me Ind. Due to (of as a conset	uence of):	er the mode or ay	ing, such as ca	irdiac or respiratory a	irrest,	Approximate Interval Between Onset and Death
98760,	icate be executed physician and s the buriat-transit	dical Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a consect	quence of):					
.O. Box (The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as in	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic pregnan Other (specify)	cy		23d. Dat Mor	e of delivery nth Day Year
<u>α</u>	puires that n signed b	ģ	Part II. Other significant conditions	contributing to death but not re	sulting in the u	inderlying cause o	pven in Part I.		. /	ribute to the cause of death? 3 ☐ Probably 4 ☐Unknown
al Records,	i: The law requir icate has been si ; page 2 should	Completed						24a. Wa: auto perf 1 (es	opsy pomed?	Were autopsy findings available prior to completion of cause of teath?
Vital	Physiclan: rthis certificated ral director, i	o Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA	thor	f Death (Check only ing Home 5 ☐ Res		er (Specify) SCENE
n of	e fe	on: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of	W	ury at ork?	28d. Describe	how injury occurr	red
Division	Attending or death. ector: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not	DB 000 Plant diam.	3:08	/	⊒Yes 21\√ZNo	V	Ween St	NCK er or Rural Route Number,
οį	7 2 2 6	Certification:	4 ☐ Homicide determined	building, etc. (Spec	ify)	ioot, tadory, omo	_	City or 10	near Rt.	
	To the Hospital c within 24 hours af To the Funeral D completely filled in	Medical (hysician: To the best of my kn miner: On the basis of examin and manner stated.						
	To th withir To th	M	29b. Signature and title of certifier	2			nse number			d (Month, Day, Year)
	(2)		30. Name and address of person who	led My) m 23a\ /T=-		OCME		DECEMBER	R 24, 2005
_	6		Tasha Z Gree	enberg M.D.			STREET	, BALTIMOR	RE, MARYI	AND, 21201
	St. Regist	ate	31. Date filed (Month, Day, Year)	3 Aegistrar's Sign	ature	ule				

		•	For StateMFIVE Registrar AV	17,18,19 10#16-1M	State	of M. 106, I	arylan Mw,Mo	id / Depa	artmen <i>rtificat</i>			and M	lental Hy	giene	005	4370	
	Physici		1. Decedent's Nam	_	Last) JAM	ES	LEC	ON JO	OHNS	ON			2. Date of Do Month Decemb	Day	Yeer 3, 2005	3. Time of Do	
	/Medic Examin		4a. Facility Name (give street and	number)			4b. City,	Town, or	Location of		Decemb		County of Dea		Γ.
			7225 Pat	terson	Street				Lan	ham				Pı	rince G	eorge's	
	Funeral		5. Social Security N		6. Sex ₹ (X)M 2□ F		je (In yrs.	last birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth	9. Bir	thplace (State or Fountry)	oreign
	Director		219-34 -		KTVIAI SCIL			67 Yrs.					Aug. 1		938 Was	hington,	D.C.
	land ow		10a. State	10b. County				ty, Town or Lo	ocation							10d. Inside City	Limits
	Mary I sh	ţō	laryland	Prince	George	S	Lanh	nam								1 □ Yes 2	⊠ No
	h the	Director	10e. Street and Nu	mber			1		10f. Zip	Code				10g. Citi	zen of What Co	ountry?	
	th wit	aiD	7225 Pat	terson	Street					207	06			Unit	ed Stat	tes	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Itam 27 is marked other than "natural", or items 23a or 28a-f show any injuryor other traumatic event, the Medical Exarts of fruit be notified at ance.	by Funerai	11. Marital Status 1 ☐ Never Man 3 ☐ Widowed	ried 2 Marrie	ld 1 □ Ye	Forces?)	i	Was Deced If Yes, spec		ispanic Ori in, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or N Rican, etc.)	0~	14. Race - Ame Black, Whit Specify: Af 1	e, etc.	
2-0	natur Ilgat	Completed	(Spe	15. Decedent'		ed)		16a. Dece	dent's Usua kind of wo	al Occupa	ation	t of worki	na	16b. Ki	nd of Business	/Industry	
21	ithin on on Ma	npi	Elementary/Second		1	e (1-4or	5+)	life.	DO NOT u	se retired)		9				
2	iled w tygiei her ti		17. Father's Name		ant) Toron	o Di	ıtler		il Sa	Les	10 Mathe	de Nome	/Cina Adidada		niture		
Maryland 21215-0036	ould be fi Mental H Marked ot	To Be	Unknown		00	S BU	истег						(First, Middle Robert				
, Mar	and 2 sh salth and n 27 is m		19a. Informant's N Nevada J Nevada Jo	ohnson .	spouse	pous	e	19b. Maili 7225	Patte	(Street a	and Number	eet,	Lanhar	ner, City o	7 Town, State, 20706	Zip Code)	
Baltimore,	Pages 1 ent of He nt: If Itar			position Cremation 5 Other (Sp		om State	0	Place of Dispo cemetery, cre t Line	matory or o	ther plac			31 -05		cation - City or		
Balti	permit. Departm Imports any inju		21. Signature of F	A	1	The	des	2	2. Name an	nd Addres	ss of Facilit	y Si		ibut	_	Rockvil	.1e
	Physician /Medical Examiner		23a. Part1. Enter shock, or hea Immediate Cause disease or conditi resulting in death)	artfailure. List o (Final on	a	n each li	ine. Crea		0	de of dyin		cardiac c	r respiratory a	irrest,		Approximate Interval Betwe Onset and Dea	47
90,	death certificate be executed eatending physician and dor use as the burial-fransit	ai Examiner	Sequentially list or if any, reauting to a cause. Enter Und Cause (Disease or that initiated event resulting in death)	erlying r injury	с.	·		quence of):									
8760,	physi physi the	dicai			d												
O. Box 6	death certif e attending od for use as	Physician/Med	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	2 months? □ No	4□Pre	e birth	of pregna 2 ∐ Feta t time of d	aldeath 3	⊒Ectopic pa ⊒ Other (sp						23d. Date of de Month	livery Day Yea	ar
ds, P.	es be	by	Part II, Other signi	ificant condition	ns contributing to	o death t	out not res	sulting in the u	inderlying o	ause give	en in Part I.			tobacco u Yes 2[o the cause of dea robably 4 X Unk	
Vital Records,	The law ate has b page 2 s	Completed											24a. Was auto perf 1 Yes	psy ormed?	24b. Were at prior to death?	utopsy findings ava completion of caus	allable se of
/ita	ician: Th certificate ector, pag	Be (25. Was case refe	rred to medical							26. Place	of Death	(Check only	one)			
of \	Physician: this certific ral director,	2	1 Tes 2 2			☐ Inpati		ER/Outpatie			4 LI NU	rsing Ho	ne 5 K Res	idence (6 □Other (Spe	cify)	
ion	ing After une	ation:	27. Manner of Dea 1 ☑ Natural 2 ☐ Accident	5 Pending investig	ation (N	ite of Inju Ionth, Da	ury ny Year)	28b. Time of Injury	of 2	28c. Injury Work 1 🗀 '	/at <br Yes 2 🗖 I		28d. Describe	how injur	y occurred		
Division	itel or Attand irs after death ral Director: /	Certification:	3 Suicide 4 Homicide	6 ☐ Could n determi	and 280. Pl	ace of In illding, e	jury - At ho tc. <i>(Specif</i>	ome, farm, st	reet, factor	y, office			28f. Location City or To			ural Route Numbe	۲,
	To the Hospitel of within 24 hours af To the Funeral D completely filled in	edical	29a. Certifier (Check only one)	1 E Certifying 2 ☐ Medical E	Physician: To examiner: On the and m	the best e basis o anner st	of examina	owledge, deat ation and/or in	th occurred exestigation	at the tim , in my of	ne, date an pinion, dea	d place, a th occurr	and due to the ed at the time	cause(s) date and	and manner as place, and due	s stated. to the cause(s)	
	To the To the Comp	M	29b. Signature an	title of certifier	11 mm						number				e signed (Mont		
	17		· w	es al	<u> </u>					DOD	57	803	2	Dec	ember	29, 200	5
	1		30. Name and add	lress of person v	. 17	MP	death (Item 나 0		Print)	Bro-	dwar	. B.	Utimor	e.N	10rular	29, 200 1d 2123	3 /
	Sta Registi	-	31. Date filed (Mo	nth, Day, Year)	2006	Regist	rar's Signa	de de	alle			, .		τ			

			For State Registrar	State of Man		epartment of Dertificate o		nd Mental Hy	/giene	05	43708
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give stru	ANES		4h City Town	, or Location of	2. Date of D Month	28	Year 5 unty of Death	3. Time of Death
	Examin	er	COASTAL HOSPIC 5. Social Security Number 6. Sex	E AT THE	n yrs. last birth	= SAL	15BUR	24	W	COM	
	Funeral Director			^{2□ F} 73	Y1	Months Day		Min. (Month, D	ay, Year)	Dela	
	Maryland -f show fied at	tor	10a. State 10b. County MD Wicomico		Dc. City, Town Hebron	or Location				1	10d. Inside City Limits 1 Yes 2 No
	with the	I Director	10e. Street and Number 110 East Lillian S	treet		10f. Zip Code 21380	9		10g. Citizen	of What Cour	ntry?
036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show the Madical Examinar mat be notified at	by Funeral		Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:	or in U.S.	13. Was Decedent of	uban, Mexican,	n? (Specify Yes or N Puerto Rican, etc.)	o- 14. F	• Race - Americ Black, White, ecify: Wh:	etc.
Baltimore, Maryland 21215-0036	be filed within 72 ho tal Hygiene. d other then "natur event, in a Madical	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)	ion ompleted) College (1-4or 5+)		ecedent's Usual Occ Give kind of work doi ife. DO NOT use ret Sales Mana	ne during most (ired)	of working		rva Alı	
yland	should be filed and Mental Hygic marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Raymond James				Laur	s Name <i>(First, Middle</i> a Wilkers	on		
, Mar	nd 2 state at 12 s		19a. Informant's Name/Relationship (Type Audrey F. James (wi	•		Mailing Address (Stre) East Lil		or Rural Route Numi	ber, City or To ron Ma		
imore			20a. Method of Disposition Y□ Burial 2 □ Cremation 3 □ Ren 1 □ Donation 5 □ Other (Specify)	ough from State	cemetery,	disposition (Name of crematory or other parties Ceme	tery 12	-31-2005	Laure	on City or To	own, State _aware
Balt	permit. Page Department Importent: It any injury o		21. Signature of Funeral Service Licensee	Hannigan-S Laurel, I	e. 199)	isharo 56	on F.H.				
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complica shock, or heart dilure. List only one Immediate Cause (Final disease or condition resulting in death)	ions that caused the cause on each line. Dillor Due to (or as a co	C	t enter the mode of d		ardiac or respiratory	arrest,	2	Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co							
.O. Box 6	the death certifi y the attending iched for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of a 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death	3 ☐Ectopic pregnar 5 ☐ Other (specify)			I	Date of delive Month	ery Day Year
rds, P	The law requires that ite has been signed b bage 2 should be deta	by	Part II. Other significant conditions contri	outing to death but n	ot resulting in t	ne underlying cause	given in Part I.		tobacco use c		he cause of death? pably 4 Unknown
Vital Records,		Completed						24a. Wa: auto perf 1 \subseteq Yes		prior to cor death?	psy findings available mpletion of cause of
of	Attending Physicien: Trideath. Indeath. Indeath. Indeath this certificate the funeral director, pa	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hos 27. Manner of Death Natural 5 Pending 2 Accident investigation	pital: 1 Inpatient 28a. Date of Injury (Month, Day Ye	2 ☐ ER/Outp 28b. Tir 9ar) Inj	ne of 28c. In	Other: 4 🗆 Nurs				(y)
Division	tal or Attendii s after death. el Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5	- At home, fam Specify)	n, street, factory, offic	ee		(Street and Nu own, State)	mber or Rura	al Route Number,
	Hospit 4 hour Funer ely fill	edical	29a. Certifier (Check only one)	an: To the best of m On the basis of exand manner stated	amination and/	death occurred at the or investigation, in my	time, date and y opinion, death	place, and due to the occurred at the time	cause(s) and , date and plac	manner as st	tated. o the cause(s)
)	To the within 2 To the complet	M	29b Signature and title of certifier	21	mo	29c. Lice	anse number	278	29d. Date sig	ned (Month,	Day, Year)
	6		30. Name and address of person who comp	leted cause of death	(Item 23a) (T	rpe, Print) P.O. Box /	733	278 Solsh	MO 3	1802	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 4 20	32. Registrar's	Signature	for box 1					

			For State Registrar		S	tate o	f Mar	yland	-			lealth : Death		lental Hy	giene		5 4	37	0
	Dhuaisi		Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year												Year	3. Time of	Death		
	Physici /Medic		WILLIA	M		MO	ORE							DECEMB		28	2005	5:3	0 A ^M
	Examir	er	4a. Facility Name (If no				n <i>ber)</i>			4b. City	, Town, or	Location	of Death				of Death		
			SUBURE 5. Social Security Num	BAN HO	SPIT	CAL	7 Ago /	la con le	ast birthday)		ETHES	SDA If Under	24 Hrs	0.5		ONTO	OMERY		
	Funeral Director					2 🗆 F		'11 yrs. 16 '3	Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da	y, Year)	022	Countr		
			579-38-72 Usual Residence of De											APRIL	10 1	932	NORTH	CARO	LINA
	ryland how		10a. State 10	0b. County			1	0c. City	, Town or Lo	cation							100	d. Inside Cit	•
	Ba-f s	ç	MD N	40NTGO1	MERY			BET	HESDA						_			1X Yes	2 No
	ath with the Marylan 23e or 28e-f show	Director	10e. Street and Number											Vhat Countr	y?				
				146 - D	4	!11.6	2 40.1					U.S.A.							
	rs after de	Funeral	11. Marital Status 1 ☐ Never Married		Was Dece Amed Fo 1 X Yes	rces?	erin U.:	5. 13.	f Yes, sp	ecify Cuba	ispanic Or in, Mexica	n, Puerto	ecify Yes or No Rican, etc.))-		e - America k, White, el			
036	hours aft	ğ	3 Widowed 4			If Yes, Give Year or Dates:				1 ☐ Yes	2X No	Specify:	:			Specify	y: BLACK		
Ď	72 ho	Completed	15 (Specify	only highest	Education	on cloted)			16a. Dece	ient's Us	Jal Occup	ation	nt of worki		16b. K	ind of Bu	siness/Indu	stry	
215	thin 7	npie	Elementary/Seconda			College (1	I-4or 5+)					during mos ()	SI OF WORK	ng					
2	lygier her th	ပိ	12th						SECU	RITY	OFF:				1	RIVAT			
nd	htal H	Be	17. Father's Name (Fir	st, <i>Middi</i> e, L2 100RE	ast)							18. Moth		<i>(First, Middl</i> e EDWARDS		Sumam	10)		
<u> </u>	12 should be fitted within 72 hou had Mental Hygiens 1; is marked other than "nature fraumatic event, the Medical E	ဥ			n /Tirne	Print)			10h Mailir	a Addror	on (Street)					Tour	State 7in (So do l	
S	d 2 s lth an 27 is trau		19a. Informant's Name/Relationship (Type, Print) SUSIE MOORE/WIFE 19b. Mailing Address (Street and Number or Rural Route Number, C 3210 NORBECK ROAD # 334 SILVER																
Baltimore. Maryland 21215-0036	permit. Pages 1 and 2 should be Depertment of Health and Menta Important: If item 27 is marked eny injury or other traumatic evonce.		20a. Method of Dispos	ition				20b. PI	ace of Dispo	sition (Na	ame of	-		ate	20c. Lo	Oc. Location - City or Town, State			
ê	Pages nent of I		1 □XBurial 2 □ 0 4 □ Donation 5			oval from	State		emete <i>ry, cie</i> r LINGTO				1/6/	2006	ART	TNG	INGTON, VIRGINIA		
<u>=</u>	permit. Depertm Importar eny inju		21. Signature of Fund			_		AIX				s ol Facili		B.JENE					
ä	20 5 3			200	1				7	474	LAND	OVER		LANDOV				2078	35
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between											veen					
	Physician		Immediate Cause (Final disease or condition Athern Sclenific Heart disease											Onset and D					
	/Medical Examiner		resulting in death) Due to (or as a consequence of):																
2	LAdminer		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Our in (Less) involve (W88885) Due to (or as a consequence of): Lubra Cere hand Bleed																
Œ,	red Ist	Examiner	cause. Enter Underlying Cause (Disease or injury						trong of Pubracerets						and Bleed				
0 .	sxecu and al-tra	xar	that initiated events resulting in death) Las		C	Due to			ience ol):	سلم	1000	ace	, 10 110						
534	icate be executed physicien and the burial-transit	dicai E			d			U	U										
. 9	tificat ng phy es the	ledic																	
10 S	eath certifi ettending for use es	N/UE	IF FEMALE: 23b. Was decedent pr		23c.	If yes, out				Tectonic i	oregnancy					23d. Dat	e of delivery	,	
× 6	a death he ette ed for	sicis	in the past 12 mo			4☐Pregn	nant at tin			Other (s						Mo	nth D	ay Y	ear
128/	that the de ad by the detached	by Physician/Me	9 Unknown																
17,	The law requires that the death certificate has been signed by the ettending page 2 should be detached for use es	þ	Part II. Other significe	. I. P20	Ap 14	outing to de	eath bul	not resu	ilting in the u	nderlying	cause give	en in Part	l.		- 1		ribute to the		
レレーテンド 12 Vital Records.	v requi	Completed		do	1	100	Tue	17 (1)	?	-				10		₩0		oly 4 □U	
3 Sec.	has has ge 2 s	ш		1)10	rbes	<i>rus</i>	17/							24a. Was		1 5	Were autops prior to comp death?	y findings a pletion of ca	variable luse of
7	ilcian: The certificate ha	မ င်	OF Man ages referred	C/ 1 4	ren	Ma								1 Yes	2. No			₩ No	
		To Be	25. Was case referred examiner? 12 Yes 2 No		Hosp	pital:	Inpatient	200	ER/Outpatier	+ 2CC	Oth			(Check only		0 1704	(0		
WILLIAM Bec	g Phys er this eral dii	n:T	27. Manner ol Death			28a. Date			28b. Time of	4 Nursing Home 5 Hesidence 6 Other (Specify)									
2 0	Attending I r death. ector: After by the funer	atlo	1	5 Pending investiga		(NOTE	iii, Day i	ear)	Injury	м		Yes 2□	No No						
Olvision of	r Atte	Certification:	3 Suicide 4 Homicide	6 Could no determin		28e. Place	of Injury	- At ho	me, larm, str	eet, facto	ry, office		:	28l. Location (City or To	Street an	d Numb	er or Rural	Route Numb)0 <i>r</i> ,
0	ital or irs afte ral Dir																		
MOORE	To the Hospital or Attending within 24 hours after death to the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one)	Certifying Medical E	Physicia xaminer:	: On the b	asis of e	xaminat	wledge, deatl ion and/or in	occurre vestigatio	d at the tin n, in my o	ne, date ai pinion, dea	nd place, a ath occurr	and due to the ed at the time,	cause(s) date and	and ma	nner as stated	led. he cause(s)	
2	To the Ho within 24 I To the Fu completely	Med	29b. Signature and till	e ol sertifier		and man	ner state	d.		25	c. License	e number			29d. Da	te signed	1 (Month, D.	av Yearl	
	F ≯ F 8			VV	ned	2	I)	M	\sim		0	53	691		1.	2/2	de		
. 0	(5)		30. Name and address	s ol person/w	to comp	leted caus	e of dea	th (Item	23a) (Type.	Print) /	-0-		0144	0 (yen	1	1	790	1 CYP C	is
CK	-0			H	JAY	RE	170	7	Mo,	(520) 1)	EVV		<i>'</i> ' <i>'</i> '	1	Mrs.	2081	7.
	Sta		31. Date filed (Month,	/		32. R	legistrar'	s Signat	ture	<i>•</i> -									
	Regist	di	JAN	0 4 200	Jb .	11/11	4	1	A CONTRACTOR OF THE PARTY OF TH										

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 5:50 PM 2005 25, December Patrick Alonzo Messam, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Bowie, Maryland 3400 Dunwood Crossing Drive If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□F 53 094-44-5873 Director 11/21/52 New York, Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County s 23a or 28a-f show Bowie Prince Georges Maryland 1X Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20721 United States 3400 Dunwood Crossing Drive death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. tems 12. Was Decedent Ever in U.S. Armed Forces? treumatic event, the Medical Examiner: 1 ☐ Yes 2 No If Yes, Give Year or Dates: within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☑ No Specify: Specify 1ack ģ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filled with Department of Heatth and Mental Hygiene Importent: If Item 27 is marked other the any injury or other treumatic event, Ins. 2008. Government Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Lee Myers Patrick Alonzo Messam, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3400 Dunwood Crossing Drive, Bowie, MD Heather Messam / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 12/31/05 Clinton, MD 21. Signature of Funeral Service Licenses 22. Papend For Efficilitiones, P.A. 20747 5538 Marlboro Pike, Forestville, MD arry A. 23a. Part1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fill ure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastatic colon cancer Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown 9 Unknown signed by the best of the sign of the detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1⊠Yes 2 No 2 ☐ ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ŏ 1🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20 D005757 ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete MD 4715 BRIAN MURPH W 31. Date filed (Month, Day, Year) State JAN 0 4 2006 Registrar

			1 = For State Registrar		Maryland /	•	artment of H		and Mental Hy	Reg2Nd)	05	43712			
3:	Physicia	an	Decedent's Name (First, Middle 1.)						2. Date of D Month	Day	Year	3. Time of Death			
-	/Medic		4a. Facility Name (If not institution	Lton F. Mon			4b. City, Town, or	Location of	December Death		2005 ounty of Death	4:00 P [™]			
1	Examin	er	930 Astern Way		.23.7		Annapol				e Arun				
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Date of B Min. (Month, D		9. Birth	oplace (State or Foreign			
	Director		577-28-3213	1 ∑ M 2□F	84	Yrs.	Month's Days	Hours	Nov.23	,1921		hington, DC			
	and **	}	Usual Residence of Decedent 10a. State 10b. County	,	10c. City, To	own or Lo	ocation					10d. Inside City Limits			
	Maryl faho	ō	Maryland Anne	Arundel	- /	nnap	olis				1	1X Yes 2 No			
	r 28a	irec	10e. Street and Number				10f. Zip Code			10g. Citize	on of What Co	untry?			
	th with	ai D	930 Astern Way,	<i>,</i> #105			214	01		Unit	ed Sta	tes			
36	should be filed within 72 hours after death with the Maryland Nd Mental Hygiene. marked other than "natural", or Items 23e or 28e-f ahow imatic event, Ita Madigal Examinar must ke multiled at	by Funeral Directo	11. Marital Status 1 Never Married Mar 3 Widowed 4 Divorced	ned 177 Yes	^{2□No} 1943-	_	Was Decedent of Hi If Yes, specify Cuba 1 Yes 2 No	ispanic Ori n, Mexicar Specify:	gin? (Specify Yes or N , Puerto Rican, etc.)		Black, White				
21215-0036	2 hou atura			nt's Education	1945		dent's Usual Occupa			16b. Kind	of Business/l	ndustry			
218	thin 7 e. en "n	Completed	Elementary/Secondary (0-12)	college (1-	-4or 5+)	life.	kind of work done of DO NOT use retired	uring mos)	t of working						
21	ygien ygien yer th	Sol		5+			Florist				ticult	ure			
Maryland	should be filed vand Mental Hygies marked other iumatic event.	Be	17. Father's Name (First, Middle, William Mo					18. Mothe	er's Name (First, Middle						
2	d 2 should th and Mer 7 Is marke traumatic	7	19a. Informant's Name/Relations			Ob Mailie	na Address (Street	and Numbe		11ian Herrel1 ral Route Number, City or Town, State, Zip Code) nnapolis, Maryland 21401 Date 20c. Location - City or Town, State /05 Baltimore, Maryland hn M. Taylor Funeral Home, Inc					
Z Z	12 th ar			89											
	s 1 and 3 Health Item 27 other tr		Louise W. Morri 20a. Method of Disposition	s / wile	20b. Place	e of Dispo	sition (Name of								
<u>E</u>	Pages nent of int: If Its iry or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5	3 □Removal from S Specify)	otate	•	matory`or other place Cremator		2/30/05	Baltin	mo re ?	Mary 1 and			
Baltimore,	permit. Pages Department of Important: If It any injury or once.		21. Signature of Funeral Service		ulta	22	2. Name and Addres	s of Facilit		aylor	Funera	al Home, Inc			
	Physician /Medical		23a. Part1. Enter the disease, or complications that cabeed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):												
H	Examiner			. Due to (t	or as a consequen	ce oi).	1								
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (c	or as a consequen	ice of):						*****			
	te be executed ysicien and ie burial-transit	Examiner	that initiated events	c											
760,	e exe sien a urial-		resulting in death) Last	Due to (d	or as a consequen	ce of):									
∞	9 %	dicai		d						-					
ox e	leath certific: attending pl	/Me	IF FEMALE:	23c. If yes, outo	come of pregnancy	,				23	d. Date of deli	VARV			
O. B	that the death led by the atten detached for u	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live bi	rth 2 Fetal de ant at time of death	ath 3[Ectopic pregnancy Other (specify)			23	Month	Day Year			
S, D	res tha igned l be det	by P	Part II. Other significant conditi	ons contributing to de	ath but not resultin	ng in the u	inderlying cause give	en in Part I	. 23e. Did	tobacco use	contribute to	the cause of death?			
ord	w require been si should b								1	Yes 2	No 3 Pro	obably 4 Unknown			
al Records,	e la hes	Completed							24a. Wa auto pen 1 🗆 Yes	s an opsy forment? 2 2 No	24b. Were autoprior to death?	topsy findings available completion of cause of 2 No			
Ĭ	sician: Th certificate rector, pag	Be	25. Was case referred to medica examiner?	Hospital:	• • • • • • • • • • • • • • • • • • • •	10	Othe	O.F.	of Death (Check only						
ō	Phys arthis aral di	. To	1 Yes 2 No 27. Manner of Death			Outpatier b. Time o	II 3 DUA	4 🗆 NU	rsing Home 5 Res		Other (Spec	orfy)			
on	nding fith.: After a funer	atior	1 Natural 5 Pendi	ng (Montt igation	h, Day Year)	Injury		k? Yes 2□	No						
5 p # 2 2		Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Num City or Town, State)									ral Route Number,			
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a, Certifier Certifyi (Check only 2 Medical	ng Physician: To the I Examiner: On the ba and mann	isis of examination	dge, deat and/or in	h occurred at the time evestigation, in my op	ne, date an pinion, dea	d place, and due to the	e cause(s) a , date and p	nd manner as lace, and due	stated. to the cause(s)			
	To the within To the Comple	Σ	29b. Signature and title of certifie	1	10		29c. License	5 l	87	29d. Date	signed (Month	n, Day, Year)			
			30. Name and address of person	Yu	600) K	Print)	A.	ven-e,	Inn.	poli	am c			
6. A.	Sta Regist		31. Date filed (Month, Day, Year)	3 2006	egistrar's Signature	R G	bank				,	,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rec: No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** DECEMBER 2005 JOHN ANDREW OWENS 12:47P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARFORD HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) Nov 6, 1949 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2□ F 220-54-5621 Maryland 56 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 28e-f show other treumatic event. The Medical Examinar must be notified at 1X Yes 2 □ No Director Aberdeen Maryland Harford 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ 21001 166 Post Road 239 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: Unknown 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☑ Married "natural', or Specify: Black 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Construction 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be fi Lura C. Putney Richard Owens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) s 1 and 2 s of Health an item 27 ls I 166 Post Road, Aberdeen, Maryland 21001 Judith A. Owens / wife ... Pages 1 a. ... pages 1 a. ... partment of Health Important: If iter any injury or once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/9/06 Garrison Forest Vet. * 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, Maryland 22. Name and Address of Facility Lisa Scott Funeral Home, P.A. 552 Lewis Street, Havre de Grace, MD 21078 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ancinoma Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 2 ER/Outpatient 3 DOA 28c. Injury at Work? Certification; Manner of De 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident

To the Hospitel or Attending Physiclen: after death Director:

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number

within 2 To the

State Registrar

Medical

31. Date filed (Month, Day, Year)

3 🗌 Suicide

29a. Certifier

4 T Homicide

32. Registrar's Signa

DHMH 17 Rev 1/2001

ORIGINAL

Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

		1	for State Registrar	State of Mai	ryland / I	Departme <i>Certifica</i>				giene Reg. No.	J5 L	3714	
	Physicia	in	1. Decedent's Name (First, Middle, La		ea/				2. Date of De Month	ath Day	Year	3. Time of Death	
	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, gives	e street and number) SASSISTE ALL I LAC. 7. Age	Livin	9 <	O I S	ocation of Death if Under 24 Hrs. Hours Min.	-	th	ounty of Deat		
	ryland how		10a. State 10b. County	1	10c. City, Tow	m or Location			<u></u>	-		10d. Inside City Limits	
	he Ma	ecto	Maryland Wicomico		Salis					10 00		Y Yes 2 No	
	3a or 2	i Di	300 Lemmon Hill	Lane		101. 2	2180	1		_	en of What Co	untry?	
5-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If a Medical Examinat must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	ver in U.S.			panic Origin? (Si Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	- 14	Race - Ame Black, White pecify: Wh	e, etc.	
21215-0	I within 72 ho iene. r than "natur It a Medical	ompleted	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	Decedent's Us (Give kind of v life. DO NOT	vork done dui	on ring most of wor	king		of Business/	Industry .vestock	
aryland 2	id be filed lental Hyg ked other ic event,	To Be C	17. Father's Name (First, Middle, Last				1		ne (First, Middle, Pepper	, Maiden S	umame)	Vescock	
lary	2 shou and M is mar		19a. Informant's Name/Relationship	Type, Print)		-		d Number or Ru	ral Route Numb	er, City or T	Town, State, Z		
e, N	1 and Health em 27 ther tr	1.5	Carolyn O'Neal (n: 20a. Method of Disposition	iece)					rel, De		e 1995		
HOL	Peges ent of nt: If its ry or o		14 Burial 2 □ Cremation 3 ['4 □ Donation 5 □ Other (Special			of Disposition (Nory, crematory or		1	3, 2006				
Baltimore,	permit. Departm Imports any inju		21. Signature of Funeral Service Lice	- Hanniger)	22. Name	and Address	of Facility	sharoon	700 W	lest St	reet	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only			not enter the m	ode of dying,	such as cardiac	or respiratory a			Approximate Interval Between Onset and Death	
	Physician // // // // // // // // // // // // //		Immediate Cause (Final disease or condition resulting in death)	a	EN	1 Staye	renal	2 disc	ane:			6 montrs	
×	Examiner		Conversion to the transmissions	a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of):								onyan	
,00	68760, ifficate be executed ig physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
68760,	ficate by	edical	,	d									
P.O. Box	To the Hospitel or Attending Physicien: The law requires that the death certif within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director. page 2 should be detached for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal death	n 3 ⊟Ectopic 5 ⊟ Other (23	d. Date of deli Month	very Day Year	
	quires thet n signed by uld be deta	þ	Part II. Other significant conditions	contributing to death but	not resulting	in the underlying	cause given	in Part I.		obacco use Yes 2 🗹	/	the cause of death?	
l Reco	The law reate has bee page 2 sho	Completed							24a. Was auto perfo		prior to death?	topsy findings available completion of cause of	
Vita	sician: certific rector.	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)								Tap	
Division of Vital Records, to Attending Physician: The law requires taler death. Director: After this certificate has been signed in by the funeral director, page 2 should be a	atlon: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day		utpatient 3 [] [Time of Injury M	28c. Injury a Work?	4 ☐ Nursing ⊓	ome 5 Resi		Other (Spec	Assisted Living		
Divis	el or Atter s after des sl Director	Certification:	3 Suicide 6 Could not l 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office 28f. L						Location (Street and Number or Rural Route Number, City or Town, State)			
	ne Hospit n 24 hour ne Funere	Medical (29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa	hysician: To the best of miner: On the basis of e and manner state	examination at	e, death occurre nd/or investigation	ad at the time, on, in my opin	, date and place nion, death occu	, and due to the rred at the time,	cause(s) a date and p	nd manner as place, and due	stated. to the cause(s)	
	To the Comp	Σ	29b. Signature and title of certifier				9c. License r				signed (Month		
,	100		30. Name and address of person who			TESAN/	1057	359		Decer	noer:	30/2005	
	70		1415 . S. DI	VI SION SI	SAZ	ISBURY	MA	21804	_				
de.	Sta Registi		31. Date filed (Month, Day, Year) JAN 0 4	32. Hamistran	's Signature	Some							

	-	For State Registrar		•	tificate of	Health and M Death	A	6N6) 5	43715	
hysicia	n	 Decedent's Name (First, Middle, La James 	L.	Do	ntos		2. Date of Death Month December 2		3. Time of Death	
/Medica	al -	4a. Facility Name (If not institution, gin		ra		or Location of Death	December 2	4c. County of	3:51 P	
1 2	£ 64	Southern Maryland Ho	•		Clinton If Under 1 Year	If Under 24 Hrs.		Prince G		
neral ector			5ex 7. Age (In yr. ▼XX M 2□ F 74	s. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth May 30,	931 Wa	B. Birthplace (State or Fore Country) ashington, DC	
fled at	tor	Maryland Prince G		City, Town or Loc Cemple Hil					10d. Inside City Lim 1 ☐ Yes 2	
st be not	ai Direc	10e. Street and Number 5503 Kenwood Street	'		og. Citizen of Wh.	at Country?				
any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2™ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 TYPES 2 NO 1 If Yes, Give Year or Dates: 195	952-	Vas Decedent of I Yes, specify Cub	dispanic Origin? (Spr an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White	
e Medical	mpieted	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give k life. D	ent's Usual Occup kind of work done OO NOT use retire CSMAN	oation during most of work d)	ing	66. Kind of Busii Furnitur	,	
c event. In	To Be Col	17. Father's Name (First, Middle, Las. Louis James Pant		Sar	esidi	18. Mother's Name	(First, Middle, M			
r traumati	۲	19a. Informant's Name/Relationship Lydia Lorraine Panto				and Number or Run reet Temple	al Route Number,		ate, Zip Code)	
ry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 □ Donation 5 □ Other (Speci	Removal from State 20b.	Place of Dispos		(e)	Date 2	-	ty or Town, State	
any injur		21. Signature of Funeral Service Lice				ess of Facility Geo. Hill koad U			L Home PA 20745	
ian ical ner	iner	23a. Ps. 1. Enter the disease or conc. ck, or heart failure, list only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	plications that caused the decone cause on each line. a	ath. Do not ente C A equence of): NAR	or the mode of dyn	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death	
	Icai Ex	resulting in death) Last	Due to (or as a conse	equence of);						
detached for use as in	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 🗆	Ectopic pregnanc Other (specify)	У		23d. Date of Month	,	
should be deta	ed by PI	Part II. Other significant conditions EMPHYSE.	contributing to death but not re	sulting in the un	derlying cause gr	ven in Part I.		_	ute to the cause of death? Probably 4 □Unknow	
page 2 sh	Completed by	· · · · · · · · · · · · · · · · · · ·					24a. Was an autopsy perform	prio dea	re autopsy findings availat or to completion of cause of th?] Yes 2 \(\square\) No	
ector.	20	25. Was case referred to medical examiner?	Manakati		To:	26. Place of Death	Check only one)		
al dir	0	1 Yes 2 No		ER/Outpatient		4 🗆 Nursing no	me 5 Resider			
completely filled in by the funeral director, page	Medical Certification;	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be								
led in by	Certif	4 Homicide determined	building, etc. (Spec	cify)			City or Town,	State)	or Rurai Route Number,	
completely filled in by the fu	edicai	29a. Certifier (Check only one) Certifying P	miner: On the best of my kinding. On the basis of examinand manner stated.	nowledge duath nation and/or inve	estigation, in my o	ns, date and place, pinion, death occurr	and dee to the eared at the time, da	te and place, and	or as stated. d due to the cause(s)	
СОП	Σ	29b. Signature and title of certifier	im		29c. Licens	number 74/		d. Date signed (A	Month, Day, Year) 9/05	
	r	30. Name and address of person who	completed cause of death (Its	em 23a) (Type P	Print)	2D FTO				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 **Physician** Month Year December 30, 4:42 P Pauline Perry /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care Nursing & Health Services Prince George's Largo If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2**XX**F Director 578-44-2935 78 November 12, 1927 Montana Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If tiem 27 is marked other than "netural", or items 23e or 28e-f show try or other traumatic event. It e Medical Exciniter must be notified at any or other traumatic event. It e Medical Exciniter must be notified at 10a. State 10b. Count 10c. City. Town or Location 10d. Inside City Limits Prince George's Maryland Clinton 1 TYes XX No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8500 Mike Shapiro Drive #421 20735 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes ZXNNo If Yes, Give Year or Dates: 1 XXIever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1 year Loan Specialist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Perry Ellen P. Ester ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Cordero / Sister 4113 Offut Drive Suitland, Maryland 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if ite any Injury or ot once. 1 XBurial 2 Cremation 3 Removal from State Resurrection Cemetery 01/03/2006 Clinton, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature of Funeral Service License 6160 Oxon Hill Road Oxon Hill, Maryland Men wann 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CORONARY ARTERY DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ysician and le burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical attending physical for use as the b IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. signed by the a 1 ☐ Yes 2xXNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? ATRIAL FIBRILLATION autopsy performed? DIABIETIES MELLITUS 2X No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) P 1 ☐ Yes 2 ☐ No 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 1 KNaturai 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide hours after To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00058290 January 3, 2005 5 30. Name and address of person who complete duse of death (Item 23a) (Type, Print) 4203 QUEENSBURY RD. HYMISULLE MS 20181 SURESHKUMAR MUTTATH 31. Date filed (Month, Day, Year) Registrar

Funeral Director 5. Social Security Number 579-64-4039 5. Social Security Number 1579-64-4039 5. Social Security Number 1579-64-4039 1	3. Time of Death 10:38 A. M unity of Death 20:38 A. M 9. Birthplace (State or Foreign Country) Chicago 10d. Inside City Limits Payes 2 \(\subseteq \) No of What Country? U.S.A.
4a. Facility Name (If not institution, give street and number) Prince George's Hospital 4b. City, Town, or Location of Death Prince Prince 4c. Cou Prince 4	9. Birthplace (State or Foreign Country) Chicago 10d. Inside City Limits MY Yes 2 \(\) No
Director S79-64-4039 1 1 M 2 F 57 Yrs. Months Days Hours Min. (Month, Day, Year)	Country) Chicago 10d. Inside City Limits M⊠Yes 2 □ No
	N⊠ Yes 2 No
D.C. Washington 10e. Street and Number 4605 Clay Street, N.E. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-) 14.	
4605 Clay Street, N.E. 20019 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	U.S.A.
TE. Was boooden Ever in o.e.	Race - American Indian,
Armed Forces? Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc. pecify: Black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Clerk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Federal Clerk Cle	of Business/Industry
4 Clerk Federa Federa 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sur Betty Gibtins	al Covernment
17. Father's Name (First, Middle, Last) Leo T. Parker 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or To	
No. Chester Lewis (Incle) 4605 Clay Street, N.E. Washington, D.C. 20	0019 tion - City or Town, State
1 XBurial 2 UCremation 3 URemoval from State Cedar Hill Cemetery January 9, 2006 Suitla	and, Maryland
21. Sonature of Funeral Service Licensee 22. Name and Address of Facility Rollins Fureral He 4339 Hunt Place, N.E. Washington, D.C.	
23a. Mr. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so ck, or hear failure. List only one cause on each line.	Approximate Interval Between Onset and Death
/Medical disease or condition resulting in death) Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Indeptying.	
figure and the cause of the cau	
Sign of the second of the seco	d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown 9 Unknown 1 Yes 2 No 9 Unknown 1 Yes 2	contribute to the cause of death?
T e e e e e e e e e e e e e e e e e e e	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 [X]No
	Other (Specify)
Oth There is no an in the contract of the cont	
28d. Describe how injury of linjury at work? 27. Manner of Death 1 X Natural 28d. Describe how injury of linjury (Month, Day Year) 28b. Time of linjury Work? 1 X Natural 2 Accident 3 Suicide 4 Homicide 28d. Describe how injury of linjury (Month, Day Year) 28b. Time of linjury M 1 Yes 2 No 28c. Injury at work? M 1 Yes 2 No 28d. Describe how injury of linjury (Month, Day Year) 28d. Describe how injury of linjury (Month, Day Year) 28d. Describe how injury of linjury (Month, Day Year) 28d. Describe how injury of linjury (Month, Day Year) 28d. Describe how injury of linjury (Month, Day Year) 28d. Describe how injury of linjury (Month, Day Year) 28d. Describe how injury of linjury (Month, Day Year) 28d. Describe how injury of linjury (Month, Day Year)	Number or Rural Route Number,
29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) an	d manner as stated. ace, and due to the cause(s)
and manner stated. 29c. License number 29d. Date s D0007967 December	signed (Month, Day, Year) per 28, 2005
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
Albert E. Rolle, MD 3001 Hospital Drive Cheverly, Maryland 20785 State 31. Date filed (Month, Day, Year) Begistrar JAN 0 4 2006	

	For State Registrar	State of Maryland	/ Depa		Health a		•	5 43718
	1. Decedent's Name (First, Middle, Last)				2. Date of D	eath	3. Time of Death
Physician /Medical	Thelma Barne	s Poole				Month Decemb	er 29 2	Year 2005 6:00 p.M
Examiner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	, or Location of		4c. County	
	4654 White Mars	h Road			dison			rchester
Funeral	Social Security Number 6. Se	7 mf =		If Under 1 Year Months Day		4 Hrs. 8. Date of B Min. (Month, D	irth (1913)	9. Birthplace (State or Foreign Country) Maryland
Director	216-14-3920	92 92	Yrs.			Dec.	9, 1913	Maryland
and	Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Loc	cation				10d. Inside City Limits
Maryl fisher for tor	MD Dorche	ster		Camb	ridge			1 XYes 2 □ No
the 1288	10e. Street and Number			10f. Zip Code)'		10g. Citizen of V	What Country?
Z with Sa Si	204 West End Av	e.			21613		US	A
ind 21215-0036 be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28e-f show event, the Madical Examinar must be notified at Be Completed by Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of	f Hispanic Orig	in? (Specify Yes or N Puerto Rican, etc.)	o- 14. Rac	e - American Indian,
or Ita	1 Never Married 2 Married	1 ☐ Yes 2 🔀 No If Yes, Give		☐ Yes 2⊠N		ruento mican, etc.)	Specify	ck, White, etc. iv: white
DO3(3 Widowed 4 □ Divorced	Year or Dates:			1 11007			
121215-00 led within 72 hou lygiene. The than "naturant, the Medical Ent, the Medical Completed	15. Decedent's Edu (Specify only highest grad	cation 1 e completed)	6a. Deced	lent's Usual Occ kind of work don OO NOT use retii	upation le during most	of working	16b. Kind of B	usiness/Industry
mylthin mathin	Elementary/Secondary (0-12)	College (1-4or 5+)		neral ma			county	government
Hygie ther int, it	17. Father's Name (First, Middle, Last)		gei	ierar ma		's Name (First, Middl		
and de fill de office of other control o	Charles E. Bar	nes				th Insley		,
Maryland 21215-0036 to 2 should be filed within 72 hours att lith and Mental Hygiene. 27 is marked other than "natural", or rereumatic event, the Medical Exam. To Be Completed by F	19a. Informant's Name/Relationship (7)	_	19b. Mailin	g Address (Stree		or Rural Route Num	ber, City or Town,	State, Zip Code)
and 2 : and 2 : a and 2 : a auth ar n 27 is	Joyce Willey	daughter	5279	Joy Row	Lane,	Salisbury	, MD 21	801
s 1 au f Head item other	20a. Method of Disposition	20b. Place	e of Dispos	sition (Name of natory or other p		Date		City or Town, State
Baltimore, Maryland 21215-0 permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene important: If item 27 is marked other than "naturally jury or other treumstic event, the Medical once. To Be Completed	1 ⊠Burial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)	temoval from State				k 1/3/06	Cambrid	lge, MD
Balti Permit. Departm Importa any inju	21. Signature of Funeral Service Licens			. Name and Add				
Dall Departiment on the control of t	3~ K.30					, Cambridg	e, MD 2	1613
Physician /Medical	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. In ecause on each line. a. Lowes Fire. Due to ras a consequen					arrest,	Approximate Interval Between Onset and Death
Examiner		Autic St						Euro.
ig limited	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequen	de Ufit:		,			10 days
D, executed an and rial-transit Examiner	Cause (Disease or injury that initiated events	Myocradin	1 1	rFanc	tien			10 days
3760, ate be executed hysician and he burial-transit	resulting in death) Last	Due to (or as a consequent	ce of):					
876(ate be hysicia the bui		d						
If Records, P.O. Box 68 The law requires that the death certifical tate has been signed by the attending phypage 2 should be detached for use as the Completed by Physician/Medicember 1.	23b. was decedent pregnant	23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal de		Ectopic pregnan	ncv			te of delivery
P.O. Box nat the death cer d by the attendin letached for use	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□ Unknown	n 5□	Other (specify)			Мо	onth Day Year
cords, P w requires that s been signed to should be dett	Part II Other significant conditions co	,	ng in the ur	nderlying cause of	given in Part I.	23e. Did	tobacco use cont	tribute to the cause of death?
rds quire an sig	Kenn tws/	rang				1 🗆	Yes 2 No	3 ☐ Probably 4 ☐ Unknown
law re as be 2 sho		J				24a. Wa	s an 24b.	Were autopsy findings available prior to completion of cause of
Vital Recipion: The law rector, page 2						per 1 ☐ Yes	ormed?	death? 1 □ Yes 2€10
/ita	25. Was case referred to medical examiner?					of Death (Check only		
on of Vital Reding Physician: The h. After this certificate his funeral director, page tion; To Be Comiton:	1 ☐ Yes 2 No	the state of the s	-			sing Home 5 ☐ Res		
ding P ding P After I funera	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Year)	b. Time of Injury	28c. In:			how injury occurr	red
VISIO Attendi death. ctor: A y the fu	2 Accident investigation 3 Suicide 6 Could not be	29a Place of Injury - At home	farm etre		Yes 2 N		/Street and Numb	per or Rural Route Number,
Division of Vital Records, tal or Attending Physician: The law requires the staffer death. at Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by	4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, iaiii, siit	set, factory, offic	8		own, State)	or or Hural House Humber,
Hospita Hospita Hours Funaral tely filled	29a. Certifier (Check only one) Certifying Phy 2 Medical Exem	sician: To the best of my knowle iner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the restigation, in my	time, date and opinion, death	place, and due to the n occurred at the time	cause(s) and ma , date and place,	unner as stated. and due to the cause(s)
To the within 2 To the comple	29b. Signature and title of conffice				nse number		_	d (Month, Day, Year)
	> W/ feetele	m.m.		D	2638	8	JAN	3,2006
	30. Name and address of person who come have Fac	ompleted cause of death (Item 23	ia) (Type, i	Print)	Hurlos	L mcl	2164	3
State Registrar	31. Date filed (Month, Day, Year) JAN 0 4	2006 Registrar's Signature	di .	Speck				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>8</u> Month **Physician** Dec 2005 3:00AM Jack H.Pippin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Glade Valley Nursing Center Walkersville 8. Date of Birth (Month, Day, Year) Feb. 23,1922 9. Birthplace (State or Foreign Country)
VA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 12M 2□F Months Days Hours 229-09-1973 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 23e or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** MD Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21793 56 W.Frederick St. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Øf Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 Yes 2 No Soecify. Completed by 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver Food Retai1 Store Pages 1 and 2 should be filed w tment of Health and Mental Hygien tent: if item 27 is marked other ti jury or other treumatic event, In. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hugh H. Pippin Mary Ottie Tinley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5317 Spy Glass Dr. Norfolk, VA

20b. Place of Disposition (Name of cametery, crematory or other place)

Date

20c. Location Karen King -Dau 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of F
Importent: if ite
any injury or ott Hampstead, MD 074 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/28/05 Carroll Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 17340 34 Maple Ave Littlestown, PA Approximate Interval Between Onset and Death Little' FH S 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician a ned for use as the burial-P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 2 → 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed has 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 1 🗌 Yes 2 ER/Outpatient 2 3□ DOA Nursing Home 5 Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: □ Natural 5 Pending 1 ☐ Yes 2 No death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide after within 24 hours a To the Funeral C 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mariner stated. 29b. Signature and tiple of certifier death (Item 23a) (Type, 10) 5 217

State
Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

MD

DEC 2 9 2005

CASPER

were & Specter

300

FREDERIC

			1 - For State Registrar	State of Ma	aryland / De	partmer <i>ertifica</i>					giene	005	437	20
(°)	7000		Decedent's Name (First, Middle, Last	t)				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		2. Date of Dea			3. Time of	Death
	Physicia /Medic		Julia Mae Proten	Lc						12/27/	/2005	5	9:20	P ^M
	Examin		4a. Facility Name (If not institution, give					Location of	of Death			County of De		
			Crofton Convales			Cro	ton or 1 Year	If Under	24 Hrs	O Data of Bird		ne Ar		
	Funeral Director		5. Social Security Number 6. Si 424–12–1796	0 M 2 X F 7. Ag	e (In yrs. last birthd 81 Yrs	Months	Days	Hours	Min.	8. Date of Birt (Month, Da 05/02/1	(924	A1	Birthplace <i>(Stat</i> e o C <i>ountry)</i> abama	r Foreign
			Usual Residence of Decedent		01		1			00,00,0				
	72 hours after death with the Maryland Instural; or Items 23s or 28s-f show deal Examinat rust be notified at	_	10a. State 10b. County		10c. City, Town o	r Location							10d. Inside Ci 1 X Yes	
	Ba-f	Director	Maryland Prince Ge	eorges	Bowie									2 1140
	vith th	Dire	10e. Street and Number				p Code				_	zen of What	Country?	
	s 23s	gra	12309 Starlight La	ane 12. Was Decedent	Ever in II S		715	ionanic Ori	ain? (Sa		JSA	14 Bace - A	merican Indian.	
	Item Iner	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	No. 3.					ecify Yes or No Rican, etc.)		Black, W		
920	urs af	þ	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 🗌 Yes	XXNo	Specify:				Specify: W	hite	
5-0	be filed within 72 hours after death with the Marylan Ital Hygiene. ed other than "natural", or Items 23a or 28a-f ahow event, the Maddal Extended read the nutities at	Completed	15. Decedent's Ed (Specify only highest gra		16a. De	ecedent's Usi	ual Occupa	ation during mos	t of work	ing	16b. Ki	nd of Busine	ss/Industry	
2	ithin han "	mple	Elementary/Secondary (0-12)	College (1-4or 5)+)	ive kind of w)			0	TT		
121	filed within Hygiene. ither than "		17. Father's Name (First, Middle, Last)	2	Hon	ne Make	er	18. Mothe	er's Nami	e (First, Middle,		Home		
Maryland 21215-0036	12 should be filed within h and Mental Hygiene. 7 Is marked other than " traumatic event, the Mes	9 Be	John Clarence Ph							Pope	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	02		
7	should nd Me mark mati	2	19a. Informant's Name/Relationship		19b. M	ailing Addres	E			al Route Numbe	er, City o	r Town, State	e, Zip Code)	
			Bonnie Tinari/ S:	ister	123	309 Sta	arlig	ht La	ne I	Bowie, N	4D 20	715		
Baltimore,	permit. Pages 1 and Department of Heall Important: If Item 2 any injury or other 2000.		20a. Method of Disposition		20b. Place of Di cemetery,	sposition (Na	ame of other plac	e)		Date	20c. Lo	cation - City	or Town, State	
E	Page nent c int: If	23	1 ☐ Burial 2Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	()	Huntt (2/29	9/2005	Wald	lorf,	MD	
alti	permit. Departn Imports any inju		21. Signature of Funeral Service Licer	S88		22. Name a	and Addres	ss of Facili	y Rot	ert E.	Evar	ns Fun	eral Hom	e
_	20E = 3		· FIX					•		ad Bowie		2071		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused one cause on each li	the death. Do not ne.	enter the mo	de of dyin	g, such as	cardiac	or respiratory ai	rrest,		Approximat Interval Bet Onset and I	ween
a de la constante de la consta	Physician		Immediate Cause (Final disease or condition resulting in death)	a Pneumoni	.a								Days	
1	/Medical Examiner		resulting in dealin)		a consequence of):								37	
76		je l	Sequentially list conditions,	b. Alzheime	r's Disea	ise							Years	
	icate be executed physician and the burial-transit	Examiner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Artery I)iseas	e						Years	
ó	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	Exa	resulting in death) Last	0.	a consequence of):									
8760,	ite be iysicië ne bui	Ical		d									-	
9	ing ph	Med	IF FEMALE:								- 1	-		
Вох	eath certific attending p I for use as I	lan/l	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic		,			2	23d. Date of Month		Year
	the a	Physician/Med	1 ☐ Yes 2 X No 9 ☐ Unknown	4∏Pregnant at 9∏Unknown	t time of death	5 Other (s	specify)							
P.0	that the de led by the a detached		Part II. Other significant conditions of	ontributing to death b	ut not resulting in th	ne underlying	cause givi	en in Part I		23e. Did t	obacco u	se contribute	e to the cause of c	leath?
Records,	uires tha signed Id be del	d by	Rheumatoid Arthr	itis						101	Yes 2	∑ No 3 □	Probably 4 🗆	Jnknown
9	w requir been si should	lete								24a. Was		24b. Were	autopsy findings	available
Re	The law	Completed								autor perfo	osy ormed? XX No	prior death	to completion of c	ause of
of Vital		a	25. Was case referred to medical					26. Place	of Deat	h (Check only o				
*	Physician: rthis certifica ral director, p	To B	examiner? 1 ⊟ Yes 2XXNo		ent 2 ER/Outpa	atient 3 🗆 🗅	Oth Oth	er: 4X Nu	irsing Ho	me 5 Resid	dence (5 Other (S	ipecify)	
0	ding Physician: n. After this certific funeral director,		27. Manner of Death 1XX Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Tim Inju	ry	28c. Injun World			28d. Describe I	how injur	y occurred		l l
Sio	Attending in death.	catl	2 Accident investigation 3 Suicide 6 Could not b			М		Yes 2 🗆	No	206 Lasstian (Ctuant an	d \$1	0	
Division	or At after of Direct in by	Certification:	4 Homicide determined	288. Place of Inj	ury - At home, farm c. (Specify)	, street, facto	ry, office			City or Tox			Rural Route Nurr	nDØr,
J	spital ours ours nersi		29a. Certifier 1 TCertifying Ph	ysicien: To the best	of my knowledge, o	leath occurre	d at the tin	ne, date ar	nd place.	and due to the	cause(s)	and manner	as stated.	
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Exer	niner: On the basis o and manner st	f examination and/o	or investigation	n, in my o	pinion, dea	th occur	red at the time,	date and	place, and	due to the cause(s	i)
	To th withir To th	×	29b. Signature and title of certifier			2		e number				-	onth, Day, Year)	-
			> Kakesh	anon!	M ME		D.	201	08	5	12	128	3/05	
			30. Name and address of person who				_				00-	1.5		
	9,5		Rakesh Arora, M.D	. 14390 Ga	allant For	x Lane	Suit	e 22	2 Boy	wie, MD	207	15		
	Sta Registi		31. Date filed (Month, Day, Year)	5 Alba	rar's Signature	mark.								

			Chata	partment of Health and N artificate _T of Death		ene 2. No: 0 0 5	43721
	Physici /Medi		1. Decedent's Name (First, Middle, Last) William A. Peters	10700 311	2. Date of Death Month Dec. 31		3. Time of Death 7:30a M
	Examir		4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital 5. Sosial Security Number = 6. Sex 7. Age (In yrs. last birthda	4b. City, Town, or Location of Death Laurel VI If Under 1 Year If Under 24 Hrs.			George's
	Funeral Director		133-32-6615 12 M 2 F 91 Yrs. Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month Day)	914 HC	thplace (State or Foreign puntar) Lland
	the Marylar 28a-1 show	ector	MD Montgomery 10c. City, Town or Silve.	r Spring			10d. Inside City Limits 1 ☐ Yes 2 📉 No
	s 23a or	rai Dir	12417 Palermo Drive	10f. Zip Code 20904		g. Citizen of What Co USA	
9600	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-1 show Ita Madical Examinar must be mylliked at	d by Funeral Director	1 □ Never Married 2 □ XMarried 1 □ Yes 2 X No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto □ Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hc Department of Healiprand-Montal Hygiene. Important: If itam 27 is marked other than "natuu eny injury or other traumatic event. It a Michael ang hour or other traumatic	Completed	(Specify only highest grade completed) (Giller Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation we kind of work done during most of work DO NOT use retired) Engineer	king 16	Mechan:	
Maryland	2 should be filed withir and-Mental Hygiene. Is markad other than aumatic evant, Ite M.	To Be	17. Father's Name (First, Middle, Last) Anthony Peters	Marie	ne (First, Middle, Ma Dohman		
	1 and 2 sh Health and am 27 is n		Sabine Hamidi/Daughter 12	iling Address (Street and Number or Rui 417 Palermo Driv	ve Silve	er Spring	g,Md20904
Baltimore,	permit. Pages 1 and Department of Health Important: If itam 27 any Injury or other to once.		1 □ Burial 2 🛣 Cremation 3 □ Removal from State Chesa :	position (Name of emalors or other place) peake Crem. 1/04,		Beltsvill	
Bai	permit. Departr Imports eny Injk		Marly Dent	PHTETPADSRIWALD 9241 Columbia B	lvd.Silv	er Sprin	ng,Md20910
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	NAL FALIU	or respiratory arrest	t,	Approximate Interval Between Onset and Death I MONTH
8760,	Examiner thysician and the burial-transit	dicai Examiner		DIVERICULIT	BLEB	DING	2 MERKS
O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and lage 2 should be detached for use as the burial-transit	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to	4
al Records,	(G C	e Completed	OF Was acces referred to medical			prior to d	topsy findings available completion of cause of
sion of Vital	ng Phys Iter this neral dii	ToB	25. Was case referred to medical examiner? 1	ent 3 DOA Other: 4 Nursing Ho of 28c. Injury at	h Check on one ome 5 ☐ Residenc 28d. Describe how	ee 6 □Other (Specinjury occurred	ify)
Division	Dir	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To tha Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, deal cartifying Physician: To the best of my knowledge,	ith occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the caus red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	D S S S S S S S S S S S S S S S S S S S	2	29b. Signature and title of certifier After A	29c. License number D 1989	7 29d.	Date signed (Month	, Day, Year)
	,		30. Name and address of person who completed cause of death (fem 23a) (Type 12 C) A HANOVER PROPERTY.	Prin Virender S	ingh MD	20770	
	Sta Registr	_	31. Date filed (Month, Day, Yeár) 32 Registrar's Signature	parte			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 28, DEC. 2005 10:45 A^M CHARLES PEFLEY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** LAUREL REGIONAL HOSPITAL PRINCE GEORGES LAUREL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F Director 225-22-9020 JAN. 27, PA. 78 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show ust be notified at 1 ¥Yes 2 ☐ No Directo PRINCE GEORGES BLADENSBURG MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5999 EMERSON ST. 20710 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 📉 No Specify: Specify: þ 3 Widowed 4 Divorced WHITE "natural" permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturi any injury or other traumatic event, Ir e Medical Once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 SALESMAN **SALES** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be PEFLEY **BROWN** NORMAN ROSE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICK PEFLEY/SON 55th PL., HYATTSVILLE, MD. 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 **X**Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ` 4 Donation CHAMBERS CREMATORY JAN.4,2006 RIVERDALE, MD. 21. Signature of Funeral Service/Licensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. / Cham M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ASPIRATION PNEUMONIA 1 DAY resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the detached 9 Unknown 9 Linknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď DEHYDRATION AND ELECTROLYTE IMBALANCE 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' certificate 1 ☐ Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 **X** No 1 X Inpatient 2 ER/Outpatient 3□ DOA 1 Yes LI S 27. Manner of Death 1 Natural 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Certification; After Japital C.
4 hours after dea.
7-ral Director: After 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, larm, street, factory, office building, etc. (Specify) determined 4 - Homicide Funeral 29a. Certifier 🔣 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. icai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. one) the within To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certification W D24721 DEC. 28, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

SYED

31. Date filed (Month, Day, Year)

SADIQ, M.D.

04

Registrar's Signature

14333 LAUREL BOWIE RD. #208, LAUREL, MD. 20708

DHMH 17 Rev 1/2001

State

Registrar

JAN 0 4 2006

ORIGINAL

			1 = For State Registrar		oartment of Health and Me <i>rtificate of Death</i>		iene og. No. 005 43724
	Dhusisi		1. Decedent's Name (First, Middle, Last,			2. Date of Deat	
	Physici /Medic		John A. Rees	se		Decembe	er 22, 2005 11:18 PM
	Examin	er	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Fort Washington H		Ft. Washington M y) If Under 1 Year If Under 24 Hrs.	aryland	Prince Georges
	Funeral Director		5. Social Security Number 6. Set 578-58-2979	7. Age (In yrs. last birthda) M 2 F 60 Yrs.	Months Days Hours Min.	8. Date of Birth Month, Day, 5/30/194	Year) 9. Birthplace (State or Foreign Country) Washington, DC
			Usual Residence of Decedent	00		5/30/154	washington, be
	yland		10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	e-fs	ctor	Maryland Prince Ge	eorges Ft. Wash	nington		1 Yes 2 □ No
	or 28	Olre	10e. Street and Number		10f. Zip Code	10	0g. Citizen of What Country?
	ath w	ral	7506 Locust Lane		20744		United States
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hyglene. Item 27 Is marked other then "naturel", or Items 23e or 28e-f show other traumatic event, it is Musical Examiliat must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Amed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexican, Puerto □ Yes 2 No Specify: 	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
Õ	2 ho	ted	15. Decedent's Edu	cation 16a. Dec	edent's Usual Occupation		16b. Kind of Business/Industry
218	en "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	ve kind of work done during most of worki DO NOT use retired)	ng	
21	e filed within al Hygiene. I other then ' vent, Ire M.	Con	/ 12		Fighter		Government
pu	be fill d oth d oth	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name		faiden Sumame)
₹ Z	2 should be and Mental Is marked sumatic ev	L _O	Joseph Reese		Bertha S		
Mai	12 st hand 7 Is n traun		19a. Informant's Name/Relationship (Ty	teacher.	iling Address (Street and Number or Rura		
	of Health item 27 l		Mary Reese / Wife 20a. Method of Disposition	7506 20b. Place of Dis	Locust Lane, Fort position (Name of penalory or other place)		ton MD 20744
nor	ages int of t: If it		1X Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	ematory or other place) Memorial Park 12/2		
altimore,	permit. Pages Department of I Important: If ite any injury or of		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 6 Funeral Service Licens		20 November 2 5 - 22		
Ba	permi Depa Impo any ir		Large &	(mar sara)	rop		1 Homes, P.A.
			23a. Part1. Enter the disease, or compl	cations that caused the death. Do not e	nter the mode of dying, such as cardiac c	r respiratory arre	st, Approximate
	Pnysician i	V.	Immediate Cause (Final	ne cause on each line.	L14 0		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):	distance lung cance		
	Examiner		Cognentially list conditions		V		
	D ##	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):			
	and trans	Examiner	that initiated events resulting in death) Last				
90,	cate be executed physician and the burial-transil	Ü	resulting in deathy Last	Due to (or as a consequence of):			
8760,		dlcal		1.			
9 X	that the death certifi ed by the attending detached for use as	Physician/Me	IF FEMALE:	3c. If yes, outcome of pregnancy	of May a Mily Standard year.		GOAL Date of delivery
Вох	atter I for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 ☐ Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
O.	y th	Jys	9 Unknown	9□ Unknown			
Ρ,	es that igned b be deta	by PI	Part II. Other significant conditions cor	ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
p	quire an sig uld b	pa p				1 ☐ Yes	s 2 No 3 Probabty 4X Unknown
Records,	The law requires ate has been sign bage 2 should be	Completed				24a. Was an	
	The lav	E O				autopsy perform	y prior to completion of cause of death? ☑ No 1 ☐ Yes 2 ☐ No
Vital		BeC	25. Was case referred to medical		26. Place of Death		
	S 0 5	10 1	examiner? 1 ☐ Yes 2√ No	lospital: 1 🙀 Inpatient 2 🗆 ER/Outpatie	ent 3 DOA Other: 4 Nursing Hor	ne 5 🗌 Resider	nce 6 Other (Specify)
n of			27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury 28b. Time (Month, Day Year) Injury	of 28c. Injury at 2 Work?	28d. Describe hov	w injury occurred
sio	Attending r death. sctor: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No		
Division	or At fter d Sirect in by	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
	To the Hospitel or Attend within 24 hours after deati To the Funerel Director: completely filled in by the		29a. Certifier 1 XCertifying Phys	Noinne To the board of the last	***		
	24 hc 24 hc Fun etely	edical		notan: To the best of my knowledge, dea ner: On the basis of examination and/or i and manner stated.	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	and due to the car and at the time, dat	use(s) and manner as stated. te and place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	. 1	29c. License number	29	d. Date signed (Month, Day, Year)
	->-0		1 Svan W	14-0	DAAMERA	1	2/24/05
9	5)		30. Name and address of person who co				مراء ااء
. (フ		BRIAN W MURPH)			VA 222	05
	Sta		31. Date filed (Month, Day, Year) JAN 0 4 2006	32. Registrar's Signature	BI		
	Registr	ar	JAN 0 4 2006	Marine Jan			

			For State Registrar	State of Man		partment of Fertificate of		nd Mental Hy	giene Reg. No.	005	437	25
	Delivata:		1. Decedent's Name (First, Middle,	Last)				2. Date of D	eath Day	Yeer	3. Time of	Death
	Physici /Medic		Elizabeth	Carmella		Robinson		Decemb	er 27	, 2005	7:30	A ^M
	Examir		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	r Location of	Death		ounty of Death		
		40	12110 Rockledge			Bowie	1 11 1-1-0			ince Ge		
	Funeral		,	1 □ M 2 🗙 F	In yrs. last birthda Yrs.	y) If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, D			place (State or ntry)	
Mg.	Director		577-20-2161 Usual Residence of Decedent	8	4 113.			01/14/	1921	Wash	ington	, DC
	land ow		10a. State 10b. County	1	Oc. City, Town or	Location					IOd. Inside Cit	y Limits
	Mary -i-eh	į	Maryland Prince	Georges	Bowie					-	XXYes	2 🗌 No
	1 the	rec	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Cou	ntry?	
	h with	Q	12110 Rockledge	Drive		20715			USA			
	be filed within 72 hours after death with the Maryland lat Hyglene. d other then "naturef", or flems 23e or 28e-f ehow event, it a Medical Exerciant must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 1;	. Was Decedent of I	tispanic Origi	n? (Specify Yes or N Puerto Rican, etc.)	0- 14	Race - Americ		
٥	after or fte	F	1 ☐ Never Married ※XMarrie			1 ☐ Yes 2 No		ruento rnean, etc.)		Black, White,	etc.	
3	uref.	d by	3 Widowed 4 Divorced	Year or Dates:		13103 22110	Opcony.		3	Whi	te	
בֿ	"natu	Completed	15. Decedent's (Specify only highest	Education grade completed)	(Gi	edent's Usual Occup ve kind of work done	during most of	of working	16b. Kind	of Business/In	dustry	
7	within ane. then	d m	Elementary/Secondary (0-12)	College (1-4or 5+)		. DO NOT use retire	a)		04	6 D1		
N	filed within 72 Hygiene. other then "nai ent, It'e Medic		12 17. Father's Name (First, Middle, L	asti	Mea	t Packer	18 Mother	s Name (First, Middle	1	t Food		
ä	d be	Be C	Joseph Clements					E. Clement		<i></i>		
Ξ	should be nd Mental marked o	မ	19a. Informant's Name/Relationshi	in (Type, Print)	19b. Ma	iling Address (Street		or Rural Route Numi		Town State Zin	Codel	
Baltimore, Maryland 21215-0036	es 1 and 2 should be fi of Health and Mental H litem 27 le marked ot r other traumatic ever		Diana J. Loeffel			-		ve Bowie,				
ē,	Hear Hear other		20a. Method of Disposition			position (Name of rematory or other pla		Date		ation - City or To	own, State	
E S	Pages nent of int; If It		1 XBurial 2 ☐ Cremation : 4 ☐ Donation 5 ☐ Other (Sp.	3 MUGILIDAGI ILOM SIGIO		coln Ceme)	2/29/2005	Brent	twood,	MD	
≣	permit. Page Department Important; If eny Injury of		21. Signature of Funeral Service					Robert E.				
ñ	De g		1/1/201			16000 Anna	apolis	Road Bowi	e. MD	20715		
	7 4		23a. Part1. Enter the disease, or on shock, or heart failure. List of	complications that caused th	ne death. Do not e		_				Approximate Interval Bety)
Е	Physician		Immediate Cause (Final disease or condition	1		Cell Lymph	om a				Onset and D	eath
5.	/Medical		resulting in death)		consequence of):	CEII Lympi	TOMA				2 1101161	10
	Examiner		Sequentially list conditions	b								
	۳ ن	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a o	consequence of):							
	and -trans	Examine	that initiated events resulting in death) Last	c	consequence of):	,						
3760,	ate be executed hysicien and the burial-transit	a E		500 10 (0) 23 2 0	oonsaquanca orj.							
687	ate hy:	dicai	11.	d								
	eath certifici attending pl	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23	d. Date of deliv	anv.	
Вох	atte	clar	in the past 12 months?	1 ☐ Live birth 2 (4 ☐ Pregnant at tin		B □Ectopic pregnanc □ Other (specify) _	У		20	Month	,	'ear
o.	at the de by the	Physician/Me	9 Unknown	9□ Unknown								
ď.	The law requires that the site hes been signed by the bage 2 should be detache	by P	Part II. Other significant condition	15 contributing to death but r	not resulting in the	underlying cause gr	ven in Part I.	23e. Did	tobacco use	contribute to t	he cause of de	ath?
ğ	w require been sig should b							1 🗆	Yes 2X	No 3 ☐ Prot	oably 4 □U	nknown
၁၁	e taw re hes be	piet				Fi		24a. Wa	s an	24b. Were auto	opsy findings a	available
Ĕ		Completed							ormed?	death?	2□ No	1030 0
<u>=</u>	iclan: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					of Death (Check only				
<u></u>	Physic this o	မ	1 ☐ Yes 2XXNo	Hospital: 1 Inpatient				sing Home 5 Res			fy)	
Ë	Attending Physiclan: r death. ector: After this certific by the funeral director,	on	27. Manner of Death 1 XNatural 5 ☐ Pending		Year) 28b. Time Injur	y Wo		28d. Describe	how injury	occurred		
S	ttend death ttor: /	cat	2 Accident investiga 3 Suicide 6 Could no	ot be	Athone for		Yes 2 N		(Street and	Mumbas as Con	-10	
Division of Vital Records,		Certification:	4 Homicide determin	building, etc.	(Specify)	street, factory, office		City or To	own, State)	Number or Rur	ai Houle Numi)e/,
	Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying	Physician: To the best of	my knowledge, de	ath occurred at the ti	me date and	place, and due to the	a cause(s) a	nd manner as s	stated	
	To the Hospital or within 24 hours after To the Funerel Dir. completely filled in It	edical	(Check only p Medical E	xeminer: On the basis of exand manner state	xamination and/or	investigation, in my	opinion, death	occurred at the time	, date and p	lace, and due t	o the cause(s)	
	To the within 2 To the complet	×	29b. Signature and little of certifier			29c. Licens	se number		29d. Date	signed (Month,	Day, Year)	
)			VY U/ KKA	MAN		D087	54		12/27	/2005		
			30. Name and address of person w	no completed cause of dea	ith (Item 23a) (Typ				,,	, 2000		
			Thomas A. Bensi			nway Cent	er Dri	ve Suite 2	05 Gr	eenbelt	, MD 2	3770
	Sta		31. Date filed (Month, Day, Year)	Registrar's								
	Regist	al	BEC 29 2	UUD CUU	K 4	Marie J						

			For State Registrar	tate of Maryland /	Depa <i>Cer</i>	rtment of Hotilitation	ealth an Death		giene 005	43726
	Physici	20	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ith Day Yea	3. Time of Death
10 × 10 × 10 × 10 × 10 × 10 × 10 × 10 ×	/Medic		Mary H. Riley					Dec.	28, 200	05 2:23 p ^M
	Examin	er	4a. Facility Name (If not institution, give stree	· ·		4b. City, Town, or		eath	4c. County of De	
	Funeral		FutureCare Chesa 5. Social Security Number 6. Sex	7. Age (In yrs. last)	birthday)	If Under 1 Year	old If Under 24		h 9. E	le Arundel Birthplace (State or Foreign
10.	Director		217-03-1700	² ₩ ^F 85	Yrs.	Months Days	Hours A	Oct. 30	/, Year)	Country) MD
	pue M	1	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Loc	cation				10d. Inside City Limits
	Maryli f eho	ō	MD Anne Arun	•		everna Pa	rk			1 ☐ Yes 2√2 No
	r 28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	th with	a D	101 Sycamore Road			211	46		USA	
980	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23a or 28a-1 ehow the Medical Exam her must be notified at	by Funerai	1 Never Married 2 Marned 1	Vas Decedent Ever in U.S. Amed Forces? Yes 252 No f Yes, Give Year or Dates:		Vas Decedent of His Yes, specify Cubar ☐ Yes 2☐√No	spanic Origin' n, Mexican, P Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ai Black, W Specify:	merican Indian, hite, etc. White
Maryland 21215-0036	be filed within 72 hours after death with the Marylar lat Hygiene. Id other than "natural", or lieme 23a or 28a-1 show of other than "natural", or liem or or lies notified at	Completed	15. Decedent's Educatio (Specify only highest grade cor		(Give l	eent's Usual Occupa kind of work done d OO NOT use retired) Secretary	furing most of	working	Social S Administ	ecurity
/land	2 should be filed and Mental Hygir is marked other aumatic event, it	To Be C	17. Father's Name (First, Middle, Last) Arthur Preston Webs	ter				Nam <i>e (First, Middle,</i> Helen Wei		
lan,	A DE E		19a. Informant's Name/Relationship (Type, I					r Rural Route Numbe		
	es 1 and 2 of Health a f Item 27 is r other tra	1	Regina R. Dulaney/D 20a. Method of Disposition			Sycamore .		Severna Pa	ark, MD 2	1146
Baltimore,	permit. Pages 'Department of H Important: If Its any Injury or ot		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State	tery, crem Land	Mem. Park	S	Dec. 31, 2005	Baltimore	e, MD
Ba	Depar Impor any Irr		21. Signature of Funeral Service Licensee		4.	95 GOV. R	itchie	Hwy, Seve	erna Park,	Funeral Home MD 21146
	Physician /Medical Examiner	niner	23a. Part1. Enter the disease, or complicatic shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	ce of):	den	Q N	diac or respiratory ar	rest,	Approximate Interval Between Onset and Death
. Box 68760,	te death certificate be executed the attending physician end hed for use as the burial-transit	Physician/Medical Examin	in the past 12 months?	Due to (or as a consequence of pregnancy 1 Live birth 2 Fetel death 2 Pregnant at time of death	ath 3	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
P.0	the che	hys	9 Unknown	9 Unknown						
	w requires that been signed b should be deta	þ	Part II. Other significant conditions contribu	//	g in the ur	lent	n in Part I.			to the cause of death? Probably 4 Dinknown
Il Records,	The law ete has b page 2 s	Completed						24a. Was autop perfor 1 Yes	sy prior t	autopsy findings available o completion of cause of ?
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ıtal:		Otho		Death Check only o	ne)	
of	Attending Physic death.	ation: To	1 195 2 LDro	1 □ Inpatient 2 □ ER/	Outpatien b. Time of Injury	28c. Injury Work	4 Hursin	ng Home 5 🗌 Resid	lence 6 Dother (S	pecify)
Division	tal or Atte	Certification:	3 Suicide 6 Could not be 4 Homicide 6 determined	8e. Ptace of Injury - At home, building, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location (S City or Tow		Rural Route Number,
	To the Hospital or Attending the Monte after de To the Funerel Directo completely filled in by the	edical	(Check only 2 Medical Examiner:	in: To the best of my knowled On the basis of examination and manner stated.	dge, death and/or inv	occurred at the tim restigation, in my op	e, date and p inion, death o	lace, and due to the opcourred at the time, o	cause(s) and manner date and place, and d	as stated. lue to the cause(s)
	To the P within 24 To the F complete	¥	29b. Signature and title of certifier	x	N	29c. License	number 5070		129d. Date signed (Mol 29 d. Date signed (Mol) (Mol 29 d. Date signed (Mol) (Mo	
			30. Name and add ess of complete son who	eted cause of death (Ite 23	a) (Type, I	Print)	a M	Mersy	le M	D-2005 D-21108
	Sta Regist		31. Date filed (Month, Day, Year) JAN 0 3 2006	32 Registrar's Signature	do	We C	7			

		For State		State of M		nd / Depa	artme	nt of H		and M	-	ygien	ຂໍ້ດີຄຸດ	•	272
Physiciar	1	1. Decedent's Name	(First, Middle, La	De al			illica	ile Of I	Dealii		2. Date of E Month	Reg. No Death		r	Time of Death
/Medica Examine	r	Mone	or Con	e street and nonbe	teme	y C	Po	Aon	r Location of		- /	40	County of De	ooth WME	M
Funeral Director		5. Social Security N 357-24-00 Usuel Residence of	68	Sex 7. A		7 Yrs.	Months	er 1 Year Days	If Under Hours	Min.	8. Date of E (Month, L June 3			Sirthplace Country) ryla	State or Fore
ms 23a or 28a-f show froust be notified at	101	Maryland	Montgom	ery		ty, Town or Lo	ocation								Inside City Lim
ritems 23s or 28s-f si ninst roust be notified	al Dire	10e. Street and Nur 10805 Roc		ive				ip Code 8 54				1	itizen of What ed Stat		
il, or ite	à	11. Marital Status 1 □ Never Marri 3 □ Widowed	ed 2⊡ Married 4 🙀 Divorced	12. Was Deceden Armed Forces 1 XYes 2 If Yes, Give Year or Dates	?]No 195	24	Was Dec If Yes, sp 1 Yes		lispanic Origan, Mexican Specify:	gin? (Spe n, Puerto I	cify Yes or N Rican, etc.)	10-	14. Race - Ar Black, WI Specify: Ca	nite, etc.	
than "natu he Medical	completed	(Spec	15. Decedent's E ify only highest gra ndary (0-12)	ducation ade completed) College (1-40	r 5+)	16a. Dece (Give life.	kind of w	ual Occup rork done i use retired	during most	t of worki	ng	16b. F	(ind of Busines	ss/Indust	ry
od other ti event, th	90	17. Father's Name (Bioch	emis				(First, Midd	le, Maidei	,	Res	earch
h and Men 7 is marke raumatic	2	Roland Ru 19a. Informant's Na Joslyn R	me/Relationship (Туре, Print)			_	ss (Street	and Numbe	r or Rura		ber, City	or Town, State		de)
int: If Item 27		20a. Method of Disp	osition Cremation 3	Removal from Stat	20b. (Place of Dispo	sition (N	ame of	T	- 0	ato	20a I	D 20854 ocation - City on ntwood	or Town	State
Department of Health and Ments Important: If Item 27 Is marked any injust on other traumatic appears.		*4 □Donation 21. Signature of F	5 Other (Special			22 S	2. Name a	and Addres	ss of Facility	y Fune	ral a	nd Cr	ematio	n Ce	nter
ysician Medical		23a. Part1. Enter the shock, or heal Immediate Cause (disease or condition resulting in death)	Final	plications that cause one cause on each a. Due to (or a	an Co	th. Do not ent	er the mo	ode of dyin	g, such as	cardiac o	respiratory	arrest,	MD 2	App	proximate erval Between set and Death
attending physician and for use as the burial-transit	cal Examiner	Security list out if any, leading to imcause. Enter Unde Cause (Disease or that initiated events resulting in death) L	mediate rlying injury	b. Due to (or a	s a consec	juence of):									
by the attending phached for use as the	ysicialiymed	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Feta	Ideath 3	Ectopic	oregnancy specify)					23d. Date of d Month	lelivery Day	Year
igned l	y y	Part II. Other signifi	icant conditions	contributing to death	but not res	sulting in the u	nderlying	cause give	en in Part I.		11		use contribute	to the ca Probably	_
ate has								-			24a. Wa aut per 1 \(\text{Yes}	opsy formed?	prior to	o comple	findings availation of cause of
- <u>2</u> 0	2	25. Was case referrexaminer? 1 □ Yes 2 □ 27. Manner of Death 1 □ Natural 2 □ Accident	No	Hospital: 1 ☐ Inpat 28a. Date of In (Month, D	ury	ER/Outpatier 28b. Time of Injury		28c. Injury Work	er: 4X Nui	rsing Hon 2	(Check only ne 5 ☐ Res 8d. Describe	sidence	6 □Other (Sp ry occurred	ecify)	
within 24 hours atter death. To the Funeral Director: Atter th completely filled in by the funeral	on in the	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	e 28e. Place of Ir	njury - At h etc. <i>(Specil</i>	ome, farm, str y)			1700			(Street ar own, State	nd Number or i	Rural Ro	ute Number,
he Funera pletely fille	edical	29a. Certifier (Check only one)	1⊠ Certifying Ph 2 Medical Exar	nysician: To the bes niner: On the basis and manner s	of examina	owledge, death	n occurre vestigatio	d at the tim n, in my op	ne, date and pinion, deat	d place, a	nd due to the	e cause(s , date an) and manner of place, and di	as stated ue to the	cause(s)
Comp	Ε.	29b. Signature and	title of certifier	3				DOO S	number 5450	66			te signed (Moi	nth, Day,	Year)
State Registrar		30. Name and address SULL FLC	a Bhoga	completed cause of	death (Iter	n 23a) (Type,	Print)	Road	d, sc	ci h	230,		SON, F	10 2	1286

		_	Tor State Registrar	State of Mi			rificate of l			Reg. No.	5 1	+3728	į
	Physicia	n	Decedent's Name (First, Middle, L						2. Date of De Month Novembe		ear	3. Time of Death	
	/Medica	al .	Charles Osborn									11:35 A	A
	Examine	er	4a. Facility Name (If not institution, g					Location of Death	1	4c. County of			
14	Funeral		Harford Memoria 5. Social Security Number 6.		e (In yrs. last b	irthday)_	Havre de		8. Date of Bir	Harfo		ce (State or Foreig	
2 2	Director		705-09-6885	4 PSZ 14 0 D E	88	Yrs.	Months Days	Hours Min.	8. Date of Bir 9/16/19	Mar)	Country Lry La	ce (State or Foreig v) ind	**
2 2 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	pu ,		Usual Residence of Decedent		140.00. =								
300	anyla show	_	MD Harf	Caro.	10c. City, Tov		ation				100	I. Inside City Limits 127 Yes 2 □ No	
22	he M	ect		ora	Aberd	een	T						_
200	with t	2	10e. Street and Number	a Chroat			10f. Zip Code	001		10g. Citizen of Wha		y?	
五日	death with the Maryland ms 23e or 28e-f show rrust be notified at	Funeral Director	305 South Roger	12. Was Decedent	Ever in U.S.	13 W	L	001	pecify Yes or No	U.S.A.		Indian	
SE SE	s after death with the Marylar, or itams 23e or 28e-f show	ᆵ	1 ☐ Never Married 2X Married	Armed Forces? 1 ☑ Yes 2 ☐ If Yes, Give				ispanic Origin? (Sp in, Mexican, Puerto	Rican, etc.)	Black,	White, et		
ر 003	3 6 0	Š	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	WWII	1	□Yes 2⊠No	Specify:		Specify:	Whit	e	
5,45		Completed	15. Decedent's (Specify only highest g	Education rade completed)	16a	. Decede	ent's Usual Occupa	ation during most of world)	king	16b. Kind of Busin	ess/Indu	stry	
22 F	vithin ne. han	mp	Elementary/Secondary (0-12)	College (1-4or !	5+)	iite. D. Agent)		Conoral I	'na	7 con	
3 20	te filed within all Hyglene. d ethar than "evant. If a Me	ပ္ပ	17. Father's Name (First, Middle, Las			Agen	-	18 Mother's Nam		General I , Maiden Sumame)	.115•	Agency	_
and and	m - @ w	o Be	Rudolph Spang	,					Osborn				
135	should be nd Men a marked imatic ev	Ė	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing	Address (Street a			er, City or Town, Sta	ate. Zip C	ode)	_
35	nd 2 alth a 27 is or trat		Gertrude Spang	(Spouse)				s St., Ak					
Je Z	ss 1 ar of Hea of Hea of Hea of Hea		20a. Method of Disposition				ition (Name of atory or other place		Date	20c. Location · Cit		n, State	
J.S.E	nit. Page artment o ortant: If injury or		1 Donation 5 ☐ Other (Spec		Spesu	tia (Cemetery	11/29	9/05	Perryman,	Mar	yland	
\$ 5 m	permit. Page Department i Important: If any ir jury or once		21. Signature of Funeral Service Lic	200	11	22.	Name and Addres	s of Facility	eral Ho	ma D A			
A SU	8.05 % N		1400.	3		1 1	berdeen)	, Marylar	id 2100	me, P.A. 1-3399			
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused y one cause on each li	the death. Do ne.	not ente	the mode of dying	/.		rrest,	lr.	opproximate nterval Between	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a INTR	A-U	RAI	SIAL	KEMI	rayy	HOE		Set and Death	Ŗ
	Examiner		-	Due to (or as	a consequence	(lor):	ML U	n der	TINES	46ULAR	101	•	
1		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence	of):	CAT FOR	AD MA	4700	BUHTI	JUN		-
	outed od ransit	Examine	that initiated events	. FRE	DUEL	M	FAL	LS /	111		4		
o,	icate be executed physician and sthe burial-transit		resulting in death) Last	Due to (or as	a consequence	of):		//	1 Janas	MEDICAL EXAMINER			
ر کر 88760	ate b	Medicai	•	d					NAPPROVED BY	MEDICAL			
Ψ	ding p	/We	IF FEMALE:	23c. If yes, outcome	of processory			CERTIFICATIO	Ma vo .				_
Box Box	eath ce attendii for use	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal deat		ctopic pregnancy Other (specify)			23d. Date o Month	r delivery	ay Year	
< 0	t the d by the tached	hysician//	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	tano or dodor	30	outer (specify)						
() a	res that igned b	by P	Part II. Other significant conditions	contributing to death b				en in Part I.	23e. Did t	obacco use contribu	te to the	cause of death?	
) rds	requires that the death certificale be executed een signed by the attending physician and nould be detached for use as the burial-transit		CORONARY	KROER	y DI	SEA	SE AN	D	1	Yes 2 □ No 3[] Probab	ily 4 🗆 Unknown	1
500	has bee	ompleted	HELPRE DISE	ASE RY	EQUIT	LIN	G AL	MI-	24a. Was			y findings available	9
Z. H	The ate has page	Com	CDAGULAY	NOI					autor perfo	irnied? dea		letion of cause of	
Z ita	E E	Be (25. Was case referred to medical examiner?					26. Place of Dear		one)			
0	£ 5 =	ပ	1 ☐ Yes 2 X No	Hospital: 1 Inpatie			3□ DOA Othe	4 Nursing Ho		dence 6 Other (
	ding P	on	27. Manner of Ceath 1 ☐ Natural 5 ☐ Pending	28a. te of Inju (Month, Ja	y ear) 28b.	Time of Injury	28c. Injury Work		28d. Describe	how injury occurred	PAR	HEAT HE	1
Division	or Attanding after death. Diractor: After in by the fune	lica	2 Accident investigati 3 Suicide 6 Could not	be Ole Place of	ury - At home, f	arm stree	et, factory, office	105 2/500	28f Location (Street and Number	OF	BED	
οï	after of after of Dirac	Certification;	4 Homicide determine	building, et	c. (Specify)	OME	Lindony, onlos		City or To	Street and Number vn, State)			5
	hours hours unara y fille	ä	29a. Certifier 1 Certifying F	Physician: To the best	of my knowledg	e, death	occurred at the tim	ne, date and place,	and due to the	cause(s) and manne	MD er as state	ad	_
		edicai	(Check only	aminer: On the basis o and manner st	f examination a ated.	nd/or inve	estigation, in my or	pinion, death occur	red at the time,	date and place, and	due to th	ne cause(s)	
	To T	Σ	29b. Signature and title of certifier	mr. i	NA	D-	29c. License	number 1/94/	^ /	29d. Date signed (A	fonth, Da	y, Year)	•
			Nava C	Bruch	7/10	A	100	3617	1	NOVEMISS	142	محريمان	1
	20+1		30. Name and address of person wh	completed cause of c	leat (Item 23a)	(Type, P	rint) (ACT)	KD ME	TORIA	HOSPI	OAL.	3013	
	State	e	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	UN	TON KA	E.J.	W/SE	de Gra	4	710.18	
	Registra	-	JAN 1 7 2006	Kannan)	& Sac	Me D							
	18	01		January Jan	A Property							5.75	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Gay1e Denise Stanmore December 25, 2005 13:14p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Southern Maryland Hospital Clinton Prince George If Under 1 Year II Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 F 578-88-0929 Director 44 Nov.4, 1961 DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examinar must be notified at 1 X Yes 2 No Maryland Prince George Temple Hills Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6107 Summerhill Road or items 23a 20748 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: Ā 3 ☐ Widowed 4 ☑ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Itsm 27 ie marked other then any Injury or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) 12th +2 Legal Secretary Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Williams Charles Edward Betty Stanmore White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Stanmore White/ Mother 6107 Summerhill Rd. Temple Hills, Md. 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1∑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/3/06 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. Clinton, Maryland 22. Name and Address of Facility
Alexander S. Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licensee ▶ 5538 Marlboro Pike Forestville, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final ickle cell **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit the death certificate be executed Exami and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 been signed by the attending physicien should be detached for use as the buria Physician/Medical IF FEMALE: 23c. Il yes, outcome ol pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1 Yes 24 hours after deeth.

Funeral Director: After this certificately filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 💢 No 1 Inpatient 2 R/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Alatural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö To the Hospitel o within 24 hours aff To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. 29b. Signature and titte of certifier 29c. License number 29d. Date signed (Month, Day, Year) D4647 30. Name and address of person who com ited cause of death (Item 23a) (Type, Print) fronts Rel Clinton mo 20735 Sureph 501 31. Date filed (Month, Day, Year) State JAN 0 4 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	•	•	1 - For State Registrar	State of IV	iaryiariu /			te of E		IG IVIE		Reg. No	- U U U	43/3	U
	Physici	200	1. Decedent's Name (First, Middle	e, Last)							Date of Dea	ath Da	y Yea	3. Time of Deat	
	/Medic		MARJORIE						EAT		ELEMP	ER	25 20	05 6:00	AM
	Examin	er	4a. Facility Name (If not institution		- 1		4b. City	, Town, or	Location of D	Death		4c.	County of De Dorch		
	C		5. Social Security Number		ge (In yrs. last b	irthday)	If Unde	r 1 Year	If Under 24	Hrs. 8	Date of Birt	h			eian
	Funeral Director		579-42-6437 Usual Residence of Decedent	1□M 2XF	75		Months	Days	Hours	Min.	Date of Birt (Month, Da Nov • 21	, Year) , 193	30 N	irthplace (State or Fore Country) EW Jersey	
4	Maryland -f ehow	Ì	10a. State 10b. County		10c. City, To	wn or Loca	ation							10d. Inside City Lin	nits
Y	a-f-s	ctor	MD Doro	chester				Hurl	ock					1 □ Yes 2 🔀	No
Z	deeth with the Maryland ime 23a or 28a-f ehow r must be notified at	al Director	10e. Street and Number 4409 Tranqui	l Trail			10f. Zi	p Code	21643			_	tizen of What (Country?	
Maryland 21215-0036	or ite	by Funeral	11. Marital Status 1 ☐ Never Married 2万≸ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes Give	, No	1[□Yes	2 ⊠ No	Specify:		y Yes or No an, etc.)		Black, Wi	nerican Indian, nite, etc. white	
5-0	72 hours "naturel"	etec	15. Deceder (Specify only highe	nt's Education st grade completed)	16	a. Decede (Give ki	ent's Usu ind of w	al Occupa ork done di	tion uring most o	f working		16b. K	and of Busines	s/Industry	
121	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)			_{ise retired)} naker				OF.	n home		
2	filed withi Hygiene. Other then	င္ဝ	11 17. Father's Name (First, Middle,	Last)			ione		18. Mother's	Name (F	irst, Middle,				
an	ould be Mental arked o	To Be	Edmund Savad							Hil			,		
ary	2 should be filed within and Mental Hygiene. is marked other then aumatic event, the Me		19a. Informant's Name/Relations		19	b. Mailing	Addres	s (Street a				r, City o	or Town, State	, Zip Code)	
Ž	and 2 patth a n 27 to er tra		Denver Spear	husban	and the second second second					, Hu	rlock	, MD	2164	3	
ore	of He of He if item		20a. Method of Disposition 1 ☐ Burial 2 MCremation	3 □Removal from State	20b. Place cemet	of Disposi ery, crema	ition (Na atory or	me of other place)	Date	9	20c. Lo	ocation - City	or Town, State	
Ĕ	Pag ment tent: I		4 Donation 5 Other (S		Salis		-			2/26/			isbury		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked ent injury or other traumatic a <u>once</u> .		21. Signature of Funeral Service	Licensee					St.,		mas Fi ridge,		al Home 2161:		
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that cause only one cause on each	d the death. Do	not enter	r the mo	de of dying	, such as ca	rdiac or r	espiratory ar	rest,	-	Approximate Interval 8etween	
	Physician		Immediate Cause (Final disease or condition	. Tint	exstit	1-1	P	Ime	vva	F	ibro	4,4		Onset and Death	-hs
	/Medical Examiner		resulting in death)	Due to (or a	s a consequenc	e of):							-		
н	Examine	_	Sequentially list conditions,	b. Thereto live	s à consequenc	. 0	-								_
	ited nsit	nlne	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	8	3 & 00/136426/10	ory.									
,	icate be executed physicien and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or a	s a consequence	e of):									
68760,	ysicie e bur	call		d											
	ntificat ng phy as th	Medical	J# ## 1 A A 1 FF												
Вох	leath cer attendir I for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No		e of pregnancy 2 Fetal dea at time of death		Ectopic p Other (s	regnancy					23d. Date of d Month	elivery Day Year	
P.O.	t the de by the a	hysi	9 Unknown	9□ Unknown											
Division of Vital Records, P	uires tha signed id be de	ρ	Part II. Dther significant conditi	ons contributing to death	but not resulting	in the und	derlying	cause give	n in Part I.		23e. Did to			to the cause of death? Probably 4 □Unkno	
ō	w requ	Completed							-		24a. Was	an	24b. Were	autopsy findings availa	able
Re	The law cete hes l pege 2 t	mo							-	_	autop perfo 1 ☐ Yes	rmed? 221No	prior to death1 1 □ Ye	autopsy findings availa completion of cause as 2 \(\subseteq \) No	of
ital		Bec	25. Was case referred to medica examiner?	1					26. Place of	Death (0	Check only o	<u> </u>	, , , , ,		
× ×	Physic this ce al dire	2	1 □ Yes 2 No		ent 2 ER/C				4 🗀 Nursi				6 □Other (Sp	ecify)	
n c	ding P h. After t funera	on:	27. Manner of Death 1 Natural 5 ☐ Pendi		ury 28b ay Year)	. Time of Injury		28c. Injury Work			d. Describe h	ow inju	ry occurred		
isic	5 0 C	icat	3 Suicide 6 □ Could		njury - At home,	farm etroe	M factor		es 2 □ No	281	Location /	Stroot as	ad Number or	Rural Route Number,	
Div	tal or A	Certification:	4 ☐ Homicide determ	building, e	tc. (Specify)	iam, stree	et, racioi	y, onice		201	City or Tox	m, State	e)	nurar noute Number,	
	To the Hospital or Attervalue of Attervalue 24 hours after de To the Funeral Directo completely filled in by the	Medical	29a. Certifier Certifyii (Check only one)	ng Physician: To the bes Examiner: On the basis and manner s	of examination a	ge, death o and/or inve	occurred	at the time	e, date and p inion, death	olace, and occurred	due to the at the time,	ause(s)) and manner d place, and d	as stated. ue to the cause(s)	
	To the within 2 To the comple	M	29b. Signature and title of certifie	er (-		29	c. License	number			29d. Da	te signed (Mo.	nth, Day, Year)	
			(CULD)	A medica	d Dort	Ov-		Res	$-\infty$	O	1)esp	meden	77 7m	ζ
			30. Name and address of person	who completed cause of	death (Item 23a) (Type, P	rint)							Maryland.	2128
			Makendra Day	ark The J	ahus H	opkir	ns H	toup: 1	al, 6	00 N	bithw	olfe	Street	Maryland Baltima	re
	Sta Registr		31. Date filed (Month, Day, Year,		trar's Signature	K	1	sell !	,						

				artment of Health and Menta rtificate of Death	Hygiene 005 43731
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last) Edward Smallwood The Fallish Name (Management and State and Sta	Dec	te of Death north Day Year 3. Time of Death onth Pay Year Par 24 2005 7:00P
	Examin Funeral		4a. Facility Name (If not institution, give street and number) 1354 Tyler Ave 5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	4b. City, Town, or Location of Death Annapolis Il Under 1 Year If Under 24 Hrs. 8. Dat Months Days Hours Min. (Mc	Anne Arundel te of Birth porth, Day, Year) 4c. County of Beath Anne Arundel 9. Birthplace (State or Foreign Country)
4	Director		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	0c	t 9 1945 Maryland 10d. Inside City Limits
21215-0036	be filed within 72 hours after death with the Maryland nat Hygiene. ad other than "naturel", or ttems 23a or 28e-f show event, The Modical Evantine must be notified at	by Funeral Direct	1 Never Married	10f. Zip Code 21403 Was Decedent of Hispanic Origin? (Specify Ye II Yes, specify Cuban, Mexican, Puerto Rican, 1 Yes No Specify: dent's Usual Occupation kind of work done during most of working DO NOT use retired)	10g. Citizen of What Country? USA ss or No- etc.) 14. Race - American Indian, Black, White, etc. Specify:Black 16b. Kind of Business/Industry
and 212	od ata b •	o Be Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ck Driver	Walton Trucking Co. Middle, Maiden Surmame) Llwood
e, Maryland	nd 2 alth ar 27 io 27 io r trau	To	Mary E. Smallwood(Wife) 1354	ng Address (Street and Number or Aural Route Tyler Ave Annapol osition (Name of Date	is, Md. 21403
altimore,	t. Page rtment o rtent: if njury or		4 □Donation 5 □Other (Specify) Pa	position (Name of Pate Metal Page of P	
m	Physician /Medical Examiner	ical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	21 West St. Annanc	olis, Md. 21401 ratory arrest, Approximate Interval Between Onset and Death
.O. Box 68	ne death certifica the attending ph thed for use as th	Physician/Med		⊒Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
Records, P	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Completed by Phy	Part II. Other significant conditions contributing to death but not resulting in the u	24	a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy lindings available prior to completion of cause of death? 1 Yes 2 No
Division of Vital	To the Hospital or Attending Physician: The I within 24 hours effer death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	To Be	25. Was case referred to medical examiner? 1		k only one) Residence 6 □Other (Specify) scribe how injury occurred
Divis	To the Hospital or Attent within 24 hours effer deatl To the Funeral Director: completely filled in by the	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, sti building, etc. (Specify)	Cit	cation (Street and Number or Rural Route Number, y or Town, State)
	To the Hospital or within 24 hours effe to the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deat a manner stated. Certifying Physician: To the best of my knowledge, deat a manner stated.	vestigation, in my opinion, death occurred at th	e time, date and place, and due to the cause(s)
	,- > F 0		30. Name and address of person who completed cause of death (Item 23a) (Type.	NOO 25 499	12/27/05
	Sta Registi		31. Date filed (Month, Day, Near) DEC 2 9 2005 Registrar's Signature	e Highway Suit	12/27/05 e 202 Arnold, MD

			For State OT I	-	Department of Health and I Certificate of Death		ene 2005 43732
	Physici	an	1. Decedent's Name (First, Middle, Last) DAVID LEE SAYE	2= 2		2. Date of Death Month	Day Year
	/Medic Examin	al	4a. Facility Name (If not institution, give street and numb		4b. City, Town, or Location of Death	DECEMBE!	2 30 2005 1:07 AM 4c. County of Death
			BATHORE VA MEDICAL	CENTER			NA
	Funeral Director		232-84-2130 ¹ √2□F	Age (In yrs. last birt	Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 1) Dec. 10	year) 9. Birthplace (State or Foreign Country) WV
	yland 10W		Usual Residence of Decedent 10a. State 10b. County	10c. City, Towr	n or Location		10d. Inside City Limits
	e Mar lifed	ctor	MD Anne Arundel		Severna Park		1 ☐ Yes 2 XNo
	death with the Maryland ims 23a or 28e-f show r must be neithing at	Director	10e. Street and Number 564 Knollwood Road		10f. Zip Code	10	g. Citizen of What Country?
	ns 23	Funeral	11. Marital Status 12. Was Decede	ent Ever in U.S.	21146	pecify Yes or No-	USA 14. Race - American Indian,
036	72 hours after death with the Marylar "neturel", or Items 23a or 28e-f show digal Execities mast be malified at	by	1 Never Married 2 Married 1 X Yes 2 If Yes, Give Year or Date	□No	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☑ No Specify:	o Rican, etc.)	Black, White, etc. Specify: White
215-0036	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	tking 10	6b. Kind of Business/Industry
7	withir ane. than	mpj	Elementary/Secondary (0-12) College (1-4	or 5+)	Pest Control		Pest Control
ם פ	Hygi ther ther	Be Cc	17. Father's Name (First, Middle, Last)			ne (First, Middle, Ma	
<u>a</u>	should be and Mental marked o	To B	Edward E. Snyder		Della M	1. Price	
Maryland 21	C1 00 - 00		19a. Informant's Name/Relationship (Type, Print) Della Snyder/Mother		. Mailing Address (Street and Number or Ru		
	1 and Health tem 27 other tr		20a. Method of Disposition	20b. Place of	564 Knollwood Road, Disposition (Name of		Park, MD 21146 Oc. Location - City or Town, State
Baltimore,	Page nent o ant: If ury or		1	RIA	cerais celletery	n. 4, 2006 —	Crownsville, MD
g	permit. Departr Importe any inji		21. Signature of Purisian Service Electrises		22. Name and Address of Facility Barranco & Sons 495 Gov. Ritchie F	.A. Sever	na Park Funeral Home
200	Physician /Medical		resulting in death)	P515	not enter the mode of dying, such as cardiac		
	Examiner	L	Due to (or Sequentially list conditions	as a consequence			
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying that initiated events c.	as a consequence of	or):		
'n	tificate be executed g physicien and as the burial-transit	Exa		as a consequence of	of);		
09/89	ate be hysicie	edicai	d				
_	certificate ding phys se as the	/Mec	IF FEMALE: 23b. Was decedent program: 23c. If yes, outco	me of pregnancy			
O. Box	The law requires that the death certif tte has been signed by the attending page 2 should be detached for use a	hysician/M	in the past 12 months?	n 2 Fetal death it at time of death	3 □Ectopic pregnancy 5 □ Other (specify)	···	23d. Date of delivery Month Day Year
7	res that igned b be deta	y Pł	Part II. Other significant conditions contributing to deal	h but not resulting in	the underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
S d	w require been sig should b	ted t	HEPATIC FAILURE			1 🗆 Yes	2 □ No 3 □ Probably 4 □ Unknown
Hecords,		Completed by P	RENAL FAILURE			24a. Was an autopsy performs	prior to completion of cause of
Vita	Attending Physicien: Ir death. sctor: After this certific by the funeral director,	Be	25. Was case referred to medical examiner? Hospital:		Othor	ath (Check only one)
	Phye er this eral dii	7: To	27. Manner of Death 28a. Date of	Injury 28b. T	Fime of 28c. Injury at	ome 5 Residen 28d. Describe how	ice 6 ☐Other (Specify) v injury occurred
on	ath. rr: After ie funer	ation	1 Natural 5 ☐ Pending (Month, 2 ☐ Accident investigation	Day Year) II	njury Work? M 1 ☐ Yes 2 ☐ No		
Division of	ospitel or Attend hours after death unerel Director; ly filled in by the f	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 28e. Place of building	Injury - At home, fa , etc. (Specify)	rm, street, factory, office	28f. Location (Stre City or Town,	set and Number or Rural Route Number, State)
	To the Hospitel or A within 24 hours after To the Funeral Dire completely filled in b	Medical (29a. Certifier (Check only one) Certifying Physicien: To the base and manne	is of examination and	o, death occurred at the time, date and place d/or investigation, in my opinion, death occu	, and due to the cau irred at the time, dat	use(s) and manner as stated. le and place, and due to the cause(s)
	To the comp	Σ	29b. Signature and title of certifier		29c. License number		d. Date signed (Month, Day, Year)
			· Crucy L M	D		16701 7	FCEMBER 30, 2005
			30. Name and address of person who Umpleted cause GRAHAM SNYPER, M. D.		(Type, Print) PEENE ST. BALTIMO!	ZE MO 2	1201
	Sta		31. Date filed (Month, Day, Year) 32. R	istrar's Signature	Ande		
	Regist	rar	JAN 0 3 2006	inference St.	STORE STORES		

			1 - For State Registrar	State of Ma			ment of H icate of L			giene Reg. No.	2005	43733
	Physicia	an	1. Decedent's Name (First, Middle, La S. Thomas Stathe	•					2. Date of De Month Decemb		Year 1, 2005	3. Time of Death 5:00 a M
	/Medic		4a. Facility Name (If not institution, giv			4b	o. City, Town, or	Location of Death	Бесень		County of Death	
	Examin		Brighton Gardens	- Bethesda			Rock	ville		Mo	ontgome	ry
	Funeral Director		5. Social Security Number 6. S 578-16-1281	ex 7. Age TM 2□F	(In yrs. last birth		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Aug • 1	v Vear)	9. Birth Cou Net	place (State or Foreign intry) W York
DO	*		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location	on					10d. Inside City Limits
Mary	feho	jo	Maryland Montgo	mery	Silv	er S	pring					1 ☐ Yes 2 🕱 No
ţ	r 28a	Director	10e. Street and Number			1	Of. Zip Code			10g. Citiz	en of What Cou	intry?
4	23a c	aiD	1213 Noyes Driv	е			20910				USA	
U.K. I.K. 13-0000 filed within 72 hours after death with the Maryland	position region feeling and Mental Hygiene. Important: it item 27 is marked other then "netural", or itema 23a or 28a-1 ehow eny injury or other traumatic event, the Medical Examiner must be indiffied at once.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Wes 2 N If Yes, Give Year or Dates:		If Ye	Decedent of Hiss, specify Cubar Yes 2 No	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	İ	4. Race - Amer Black, White Specify: Wh:	
	netur	eted	15. Decedent's E	ducation ade completed)	(Give kind	's Usual Occupa d of work done d	uring most of worki	ing	16b. Kin	d of Business/li	ndustry
ithin	hen.	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. DO l	<i>NOT</i> use <i>retired)</i> .tect			Δrc	chitect	ıra
יון קליים קליים	Hygie ther t	e Co	17. Father's Name (First, Middle, Last,)	F	TCIII	tect	18. Mother's Name	e (First, Middle,			116
2 2	ked o	To Be	Thomas Peter Sta						atrivan		,	
Mai y	Ith and M 27 ie mar r traumat	-	19a. Informant's Name/Relationship (Joanne Stathes/			Mailing A		nd Number or Rura				
בי ביים פינים	int: it item		20a. Method of Disposition 1 StBurial 2 Cremation 3 4 Donation 5 Other (Specif			cremato	in (Name of ory or other place orial Park	1			ation - City or T	own, State
	Departm imports eny inju		21. Signature of Funeral Service Licer	nsee		F 22 alf 500	reisd Addres Univers	Collins lity Blvd	Funeral , W, Si	Home lver	Inc Spring	, MD 20901
П			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each line	the death. Do no	t enter th	ne mode of dying	, such as cardiac o	or respiratory ai	rrest,		Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition		tory Fai	lure						Onset and Death
	/Medical xaminer		resulting in death)	Due to (or as a	consequence of):						
		er	Sequentially list conditions, if any, leading to immediate	b. Bactere	mia consequence of):						
1	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. Type I	Diabetes	Mel	litus					
5	en an		resulting in death) Last		consequence of							
dor do,	physicien and s the burial-transit	edicai	•	d								
	ding p		IF FEMALE:	220 If you cutooma s	of prognancy							
	within 24 bours aftar death. To the Furnorus aftar death. To the Furnorus aftar death. Completely filled in by the funeral director, page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at the 1 Unknown	Petal death		opic pregnancy her <i>(specify)</i>			23	3d. Date of deliv Month	rery Day Year
ביים ביים	signed b	þ	Part II. Other significant conditions of Parkinson's Disea	contributing to death bu se, Senile	t not resulting in Dementi	the under	lying cause give)steomye	nin Part. Litis,		obacco us Yes 24		the cause of death?
5	s beer	iete	Prostate Hyperpla	sia					24a. Was		24b. Were aut	opsy findings available
ביים דרים	ficete hes	e Completed		514					1 ☐ Yes	rmed? 2 No	prior to α death? 1 ☐ Yes	ompletion of cause of
	s certi	To Be	25. Was case referred to medicat examiner? 1 ☐ Yes 2X No	Hospital:	nt 2 ER/Out	nationt 3	3□ DOA Othe	26. Place of Death 17: 4 ☐ Nursing Ho			Other (Spec	6.0
	h. After thii funeral c	Certification: T	27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	/ 28b. Tii	ne of ury	28c. Injury Work		28d. Describe I			'97
	r deat ctor: by the	ifica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Inju	ry - At home, farr				28f. Location (Street and	Number or Rur	al Route Number,
בֿ בֿ	rei Dir		4 Homede	building, etc.					City or Tox			
e d	in 24 houth	edicai	29a. Certifier Check only one) Medical Exam	nysicien: To the best of miner: On the basis of and manner stat	f my knowledge, examination and ed.	death occorring	curred at the timing ation, in my op	e, date and place, inion, death occurr	and due to the ed at the time,	cause(s) a date and p	and manner as a place, and due t	stated. to the cause(s)
F	To To To To To To To To To To To To To T	2	29b. Signature and title of certifier	1110, G	Jofact	•	29c. License				signed (Month,	
h	5+1		30. Name and address of person who	completed source of d	ath (Item 22a) /7	iuna Dei-	H458	39		Dece	ember 3	1, 2005
			Gary Raffel, D.C	. FACP 541	1 W. Ced	lar I	Lane, #2	02A, Betl	hesda,	MD 20	0814	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 04 2	324Registra	r's Signature	hoese	E)					

			1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of I			giene	5 43734
	Physici /Medic		1. Decedent's Name (First, Middle, La	ost)				2. Date of Dea Month	Day	Year 7.25 PM
	Examin		4a. Facility Name (If not institution, gir			4b. City, Town,	or Location of	Death	4c. County	
	F 1		5. Social Security Number 6.		ge (In yrs. last birthday		oung If Under 2	4 Hrs. 8. Date of Birt	Wice	
	Funeral Director		,	1 □ M 2 137 E	80 Yrs.	Months Days		Min. 8. Date of Birtl (Month, Day	, Year) 1925	Birthplace (State or Foreign Country) Maryland
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Maryli -1 eho	tor	Maryland Worces	ster	Berl					Maryes 2 No
	ith the Marylan or 28a-1 ehow ne notified at	lrec	10e. Street and Number			10f. Zip Code			10g. Citizen of W	What Country?
	ier death wi items 23a mer namt b	ral	234 Ocean Parkwa			21811			USA	
920	E o a	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ ₩Divorced	12. Was Deceden Armed Forces 1 Tyes 2 Kill Yes, Give Year or Dates:	?]No	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 25 No		in? (Specify Yes or No- Puerto Rican, etc.)	14. Race Black	a - American Indian, k, White, etc. : white
1215-0036	within 72 hours iene. then "netural", the Madical Exe	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation a <i>de completed)</i> College (1-4or	(Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most (d)	of working	16b. Kind of Bu	siness/Industry
d 21	filed withi Hygiene. other then		9 17. Father's Name (First, Middle, Las	-	Home	maker	18. Mother	s Name (First, Middle,	Domes Maiden Surname	
lan	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental Berner and a second to the Mental Berner Be	To Be	William Thompson	1				y Machin		
Maryland	2 should and Menis markers aumatic		19a. Informant's Name/Relationship					or Rural Route Numbe		
	s 1 and 3 if Health Item 27 other tr		Mary Deborah We	est/daught		AND REAL PROPERTY AND REAL PRO		ail, Venice		293 City or Town, State
mor	0 0		1 ☐ Burial 2 🛣 Cremation 3 [4 ☐ Donation 5 ☐ Other (Special		20b. Place of Disp cemetery, cre Salisbur		1			
Baltimore,	permit. Page Depertment o Importent: if any Injury or once.	3	2 Signature of Fune al Service of e		Î	2. Name and Addre	ess of Facility. Funera		Salisbu Tessiona Drv. MD	1 Association
	=	7	23a. Part. Enter the disease, or conshock, or heart failure. List only	polications that care	d e death. Do not en	ter the mode of dyi	ng, such as c	ardiac or respiratory ar	rest,	Approximate Interval Between
i e	Physician		Immediate Cause (Final disease or condition resulting in death)	a	DE CA	NCER	- 5	PULOYDE	5 CE	Onset and Death
No.	/Medical Examiner	er		b	s a consequence of):	5 - 1	1007	PUROYDE VARCY ECTTOR	TRAC	9
	be executed sicien and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	s a consequence of):		/	7///		
8760,	ate be ex nysicien he buria		(d						
O. Box 68	The law requires that the death certificate be executed tte has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	y		23d. Date Mon	e of delivery hth Day Year
rds, P	w requires that the been signed by should be detact	by	Part II. Other significant conditions	contributing to death	but not resulting in the t	ınderlying cause gr	ven in Part I.	24		ibute to the cause of death? 3 Probably 4 Dunknown
Records,	The law requate has been bage 2 should	Completed						24a. Was a autop. perfor	sy pi med? di	Vere autopsy findings available rior to completion of cause of eath? ☐ Yes 2☐ No
Vital		Be	25. Was case referred to medical examiner?	100				of Death Check only or	-	
of \	Physician: rthis certific ral director.	T:	1 ☐ Yes 2 No 27. Manner of D ath	Hospital; Inpat		III JU DOA		ing Home 5 Resid		
OU	Jing After fune	tlon	1 Natural 5 Pending	(Month, D	ay Year) Injury	Wo	rk?]Yes 2 □ N		ow injury occurre	ed
Division	al or Attendii s after death. I Director: Al d in by the fu	Certification:	3 Suicide 6 Could not l 4 Homicide determined	286. Place of Ir	njury - At home, farm, st tc. (Specify)	reet, factory, office		28f. Location (S City or Tow	treet and Numbe n, State)	er or Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th gompletely filled in by the funeral	edical (29a. Certifier Check only one) Certifying P	hysician: To the bes miner: On the basis and manner s	t of my knowledge, deat of examination and/or in tated.	th occurred at the truestigation, in my o	me, date and opinion, death	place, and due to the o occurred at the time, o	ause(s) and mar late and place, a	nner as stated. and due to the cause(s)
	Withi To t	Σ	29b. Signature and title of certifier	2		29c. Licen:			29d. Date signed	(Month, Day, Year)
	13		of aree c	U O	ceele		>14		121	7/10
	3		30. Name a address of person who	completed cause of	death (Item 23a) (Type	Print)	7.AL	HOTTLE AUSBURY	1 1 (V	> 2/80/-
-	Sta	ite	31. Date filed (Month, Day, Year)	,	trar's Signature	/ Core	/ //	1 -1 71 - 40	1-11-	
	Registr	ar	JAN 04:	2006	us. H. D	cast s				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Yeer 1825 AM SON 2005 31 e devi December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cambridge Dorchester General HOSPHA 1 If Under 1 Year | II Under 24 Hrs. 9. Birthplac 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 100 M 2□F Hours 4-07-8236 **Director** Usual Residence of Decedent Yrs. filed within 72 hours after death with the Maryland 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location or items 23a or 28e-f show treumatic event, the Madical Examinar must be notified at 1 Yes 2 No Director .OC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 5 U Completed by Funeral street 6 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No II Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☑ Divorced Specity: "netural", Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Şecondary (0-12) College (1-4or 5+) Self-Employed [0 arpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ould be Martin Pages 1 and 2 should nent of Health and Men e 55 2 ant' Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jes 1 and 2.
Jes 1 and 2.
Jes 1 and 2.
Jes 1 and 2.
Jes 1 and 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2.
Jes 2. 816-Cambridge Date 20c. Leating Mary and 21613 Bradley Grubb Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Lenti A - City or Town, State 1 Burial 2 Tremation 3 Removal from State d-ShoreCrenation 106 ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HENRY FUNERAL HOME P.A. 23a. Patri. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. dye, MD. 21613 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** pneumai 5 days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 6h Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by erei Director: After this certificate has been signe filled in by the funeral director, page 2 should be 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 Tes 2 No within 24 hours after death. To the Funerel Director: A 2 Accident investigation Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier in 🖟 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300

State Registrar 31. Date filed (Month, Dyn Year)

2006^{S2.} Registrar's Signature

6

			Please	Type or Pri				x. Assure All Health and M	-	_		0706
							icate of			Reg. No.	4 CL	3736
	Physici	an	1. Decedent's Name (First, Middle, L.						2. Date of Dea			Time of Death
	/Medic			e G. Timberl					Lecember	23 ^{ay} 2005	9):30 PM
٧	Examir	er	4a Fecility Name (If not institution, gi 14509 Duckett Road	ve street and number)			4b. City, Town, or Lo Brandywine		Prince	of Death George's	
45	Funeral Director		577-40-6780	Sex 7.A 1□M 2XXF	ge (in yrs. last 81		Under 1 Year onths Days		8. Date of Birt (Month, Day Septembe	r, Year) r 10, 192	9. Birthplace Country) 24. North	(State or Foreign
	anyland show		Usuel Residence of Decedent 10a. State 10b. County		10c. City, To	own or Locati	on		1		200	nside City Limits
	h the Marylar r 28a-f show	to	Maryland Prince Ge	orge's			J	Brandywine			1	Yes 2□No
	vith the	Funeral Director	10e. Street and Number		1		Of. Zip Code	20613		10g. Citizen of V U.S.		
	eath w	erai	14509 Duckett R	12. Was Deceden	Ever in II S	13 Was	Decedent of		noity Vos or No		e - American Ir	ndian
50	72 hours after death with the Maryland natural', or flems 23a or 28s-1 show Sical Examiner must be notified at	y Fun	1 Never Married 2 Married	Armed Forces 1 Yes 2 If Yes, Give	?		s, specify Cut	Hispanic Origin? (Sp pan, Mexican, Puerto Specify:	Rican, etc.)	Blac Specify	ck, White, etc.	ndian,
9	natural',	ed by	3 Widowed 4 □ Divorced 15. Decedent's E	Year or Detes:								
215	.⊆ ∰	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or		(Give kind	's Usual Occu d of work done NOT use retire	during most of work ad)	ing	16b. Kind of Bu		
21	a filed within al Hygiene. I other than vent, the Me	E	12th grade	College (1-4or	5+)	Super	visor			U.S. Coa	ast Guard	(Retired)
Maryland 21215-0020	D = 0 •	To Be	17. Father's Name (First, Middle, Las. Wright	•				18. Mother's Name	Josephine		16)	
	ges 1 and 2 should be it of Haalth and Mental If itam 27 is merked o or other traumatic eve		19a. Informant's Name/Relationship Mr. Wayne C. Timberla		1)	9b. Mailing A 14509 I	ddress <i>(Str</i> ee Lickett]	t and Number or Run Road Brandyw	al Route Numberine, Mary	r City or Town. Land 200	State, Zip Cod	fe)
Baltimore,			20a. Method of Disposition 1 ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑		ceme	of Disposition tery, cremator and Nat	ry or other pla	norial Park	Date December	20c. Location - 30, 2005		
Balt	parmit. Pe Departmer important: any injury once.		21. Signature of Funeral Service Lice	Indon	m /	1 2000	me and Addr	ess of Facility R Lace, N.E. W	ollins Fl ashinglor		ACR TAX CO. 15 T. 1	
No.	Physician		23a and Enter the disease, or con- ck, or hear failure. List only	plications that cause one cause on each l	d the death. Dine.	o not enter th	ne mode of dyi	ng, such as cardiac	or respiratory an	rest,	Inte	proximate rival Between set and Death
	/Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)	aM	ETA-S	TATI	C	CANC	ER.			
	₽ #	ner	_		Due to (or as	a consequen	ce of):					
0,	axecuted an and urial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D	Due to (or as	a consequen	ce of):				l I	
9289	certificate be iding physiciuse as the bu	edical	Cause (Disease or injury that initiated events resulting in death) Last	C	Due to (or as a	consequen	ce of):				1	
Box	ending r use	an/M		d								
P.O.	v requiras that the daath certificate be a: been signed by the attending physician should be datached for use as the buria	/ Physician/Medica	Part II. Other significant conditions of	contributing to death I	out not resulting	in the under	tying cause gi	ven in Part I.			atribute to tha	causa of death?
Records,	w requiras that the s been signed by th ? should be datache	Completed by							24a. Was e	en autopsy med?	availabl	utopsy findings le prior to tion of cause
	The law ate has page 2	Eo							1 🗆 Y	es 2 DNo		s 2[X]No
of Vital		Bec	25. Was case referred to medical examiner?					26. Place of Death				
> >		2	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpati		Outpatient 3	DUA	her: 4 Nursing Ho	me 5 Aesid	ence 6 Oth	er (Specify)	
ono	tending Ph leath. tor: After th the funeral	tion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Dete of Inju (Month, Da	ay Year) 28b	. Time of Injury	28c. Inju Wo И 1 □	ryat rk?]Yes 2 □ No	28d. Describe h	ow injury occurr	red	
Division	i or Attending after death. Director: Afte d in by the fune	Certification:	3 Suicide 6 Could not be determined	e 28e. Place of In	jury - At home, tc. (Specify)		-		28f. Location (S City or Tow	treet and Numb n, State)	er or Rural Rou	ıte Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After complataly filled in by the funer	edical C	29a. Certifier (Check only one) 1 Certifying Properties of the control of the control of the certified of t	nysician: To the best niner: On the basis of and manner si	if examination a	ge, death occ and/or investi	curred at the ti gation, in my o	me, date and place, appinion, death occurr	and due to the c ed at the time, d	ause(s) and ma ate and place, a	nner as stated. and due to the	cause(s)
	To the within To the compl	¥ -	29b. Signature and title of certifier				29c. Licens	se number	2	9d. Date signed	d (Month, Day,	Year)

State

30. Name and address of person.

Sortin Verchet

31. Date filed (Month, Day, Year)

JAN 0 4 2006 Registrar



ed cause of death (Item 23a) (Type, Print)

D53782

3rd

MD

2006

JAN

ROAD, SUITE #101, FORT WASHINGTON

			State of Maryland / Department of Health Certificate of Death		ygiene Reg. No. () (43737
	· ·		Decedent's Name (First, Middla, Last)	2. Date of E	eath	, <u>C</u>	3. Time of Death
	Physici /Medio		Helen Lee Thomas	Decemb	Day per 29, 2	Year 2005	7:50am
2	Examir			Town, or Location of Dea	ath 4c. County	of Death	
				tsville	Prin	ice Ge	
	Funeral		Months Days Hours		irth Da <i>y, Year)</i>	9. Birthpla Count	ace (Stata or Foreign ry)
	Director		579-22-1597 84 Yrs. Usual Residence of Decedent	March	11,1921	South	Carolina
	yland		10a. State 10b. County 10c. City, Town or Location			10	d. Inside City Limits
	e Mar	ctor	Maryland Prince George Hyattsville				Yes 2□No
	if the series	Funeral Director	10e. Street and Number 10f. Zip Code		10g. Citizen of	What Count	ry?
	ath w	rai	5453 Newton Street Apt. #2 20784	-	United	State	S
	er de	une	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic C	Origin? (Specify Yes or Nan, Puerto Rican, etc.)	lo- 14. Rad Blad	e - America	
20	72 hours after death with the Maryland netural', or Hems 23a or 28s-f ehow likal Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☐ No Specifi Year or Dates:	jy:	Specify	Black	
21215-0020	tural cal E	Completed by			16b. Kind of B	usiness/Indi	istni
215	n 72 n n	plet	15. Decedent's Education (Spacify only highast grada completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Giva kind of work done during mo	ost of working	TOD. KING OF B	23111033711101	astry
21	d with	ĕ	12th Housekeeping		Milita	ry	
p	el Hy el Hy l othe vent,	Be		her's Name (First, Midd	a, Maidan Sumen	ne)	
yla	Ment Ment arked	2		nie New			
Maryland	2 short and is made is made		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Num.		, , , , , , ,		
6	l end lealth m 27 her t		Lloyd Brown / Son 5448 Mar1stone Lan				
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours atter death with the Marylan Dependent of Health and Mentel Hygiene. Important: If Item 27 is marked other then "netural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.	!	20a. Method of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Place of Disposition (Nama of camatary, cramatory or other place)	Date	20c. Location -	-	
Ħ	t. Pe rtmer rtant:	į	4 Donation 5 Other (Specify) Ft. Lincoln Cemetery	11 11 00	Brentwo		d.
Bal	permi Depe Impo any Ir		21. Signature of Funeral Service Licensee 22. Name and Address of Faci	llity Pope Funera	1 Homes,	P.A.	
			5538 Marlboro	_Pike Fores	tville,	Md. 2	
			23a. Pert1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.	s cardiac or respiratory	arrest,	i	Approximate Interval Between Onset and Death
7	Physician /Medical		Immediate Cause (Final		~ `	1	onset and beath
	Examiner		disease or condition resulting in death) a. Hyper Temp1 Ve Card 10	vasaular	mee	we	
		Je.	Due to (or as a consequence of):			1	
	ficete be executed I physiclen end is the buriel-transit	Examine	Sequentially list conditions. Due to (or as a consequence of):	70.70		1	
ó	en er len er iriel-t		if eny, leading to immediate			1	
68760,	fficete be executed physiclen end as the buriel-transit	edical	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
<u>8</u>						ŀ	
Вох	law requires thet the death certif es been signed by the ettending s 2 should be deteched for use a	Physician/M					
Ö	the e	ysic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	11. 23b. Did	tobacco usa co	ntribute to t	he cause of death?
P.0	thet the ed by detection	된	Daletes Type 2	1	Yas 2□ No	3 Probe	bly 4 Unknown
ds,	signe d be	d b	Cal	240 14/0	on autonov	24h Wor	e autopsy findings
Ö	requ been shoul	ete	UST ROOUTLINTS	per per	s an autopsy ormed?	avail com	eble prior to pletion of cause
Re	The law ate hes pege 2	Completed	Lucular a Padicalla noth		_		eath?
<u>ra</u>	icien: The certificate rector, peç		25. Was case referred to medical 26. Place		Yes 2 ₩ No	10	Yes 2□ No
of Vital Records,	ysicien: The la is certificate he director, pege	To Be	examiner?	ce of Death (Chack only lursing Home 5 A Res		/C¥-/	
0	g Phys er this eral di		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		how injury occurr		
Division	ath. r: Afte	Certification:	1.22(Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □	□No			
Vis	er de recto	# 발	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location	(Straat and Numb	er or Rural I	Pouta Numbar,
	tal or rs eft el Dia	Ce	building, sic. (opearly)	July of 10	win, Otaley		
	To the Hospital or Attending Physicien: within 24 hours eiter deals and the Funerel Director. After this certification pletely filled in by the funeral director, completely filled in by the funeral director.	cal	29a. Certifier (Check only a Check only Check only 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, de	nd place, and due to the	cause(s) and ma	nner as stat	ted.
	within 24 To the F complete	Medical	and manner stated.	trib tille			
	5 4 k 5		29b. Signature and title of certifier 29c. License number	03 -1	29d. Date signed		
		-	Jeffrey M. Weinfield MD DO032	758	29-D	ec-	1003
1	(5)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fort Lin (O	Tu Fam. 1	red Ctr	1 21	707-
			31. Date filed (Month, Day, Year) 32. Registrar's Signature	-01 Colma	riplance	r, MI	1 10+12
	Sta	ρ.					1

DHMH 16 Rav 6/95

		1 - State Registrar Amend Item		FH G85€	r/26/1060t	pp eath		g. No. U U U	43738
Physici	an	Decedent's Name (First, Middle, Last JANE D. VENSO					2. Date of Death Month	Day Y	3. Time of Death
/Medic	cal				45 C 7-		December		05 7:25 am
Examin	ier	4a. Facility Name (If not institution, give				or Location of Deat	n	4c. County of	
		Suburban Hospital 5. Social Security Number 6. S		(In yrs. last birthday)	Bethesd If Under 1 Year		8. Date of Birth	Montgo	
Director		577-32-9770	□M 2 X F	80 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, July 29,	Year) 1925 W	Birthplace (State or Foreign Country) ashington, Description
Mo M		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limit
- 3	ţċ	DC		Washingto	n				1 x Yes 2 □ N
or 28.	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wha	at Country?
23a	al	314 East Capitol	St. NE		2000	3		USA	
gene. r than "natural", or items 23a or 28a-f ehow tra Medical Exercites mast be notified at	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S ban, Mexican, Puer	pecify Yes or No- to Rican, etc.)		American Indian, White, etc.
0 J	by Fi	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates:	0	1 ☐ Yes 2X No				Black
and and	edk	15. Decedent's Ed	l	16a Dece	dent's Usual Occu	nation	1.	6b. Kind of Busir	
a diam	Completed	(Specify only highest gra	ide completed)	(Give		during most of wor	rking	OD. KING OF BUSH	less/industry
d other than ivant, Ine Me	E	Elementary/Secondary (0-12)	College (1-4or 5-		leswoman	1		Private	i
ent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, M.	aiden Surname)	
V =	To E	Henry Stewart				Everly:	n Jones		
4 3	1	19a. Informant's Name/Relationship (-		ural Route Number,		
tem 27 l	0.3	Charlotte Smith/	Sister			Street 1	NE Washing	gton, DC	20017
If Iter		20a. Method of Disposition 1 Substitute 2 Cremation 3 C	Removal from State	20b. Place of Dispo		nce)		Oc. Location · Cit Washing I	
ury o	1 8	4 ☐ Donation 5 ☐ Other (Specify		Harmony M	emorial :	Pk. Jan.	7,2006 L	andover:	, 111)
Important: If Ite any Injury or of once.		21. Signature of Funeral Service Licen	isee	1 22	2. Name and Addre	ess of Facility ${f John}$	nnson and	Jenkins	Funeral Hom
= a a		23a. Part1. Enter the disease, or corn shock, or heart failure. List only	Long				t NW Washi		DC 20011
physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. CEREBRAL	EDEMA consequence of). INFARCTION consequence of):	N				
tached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 N No	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at the 10 ☐ Unknown	Fetal death 3	Ectopic pregnanc	у		23d. Date o Month	f delivery Day Year
be de	Ď	Part II. Other significant conditions of	ontributing to death but	t not resulting in the u	nderlying cause giv	ven in Part I.			ite to the cause of death?
should	ted						1 L Yes	2. A JNo 3[☐ Probably 4 ☐ Unknow
page 2 sho	Completed						24a. Was an autopsy performe	prio ed? dea	re autopsy findings availab r to completion of cause of th? Yes 2 \(\text{No} \)
tor, p	0	25. Was case referred to medical				26. Place of Dea	ath (Check only one)		163 2 100
directed directed	To B	examiner? 1 ☐ Yes 2 📉 No	Hospital:	t 2 ER/Outpatien	it 3 DOA Ott	200	lome 5 Residen		Specify)
the funeral		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	Wo		28d. Describe how		
ρ	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, farm, str (Specify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number o State)	or Rural Route Number,
.ii		29a. Certifier 1 Certifying Ph	ysician: To the best of	examination and/or in	n occurred at the ti vestigation, in my o	me, date and place opinion, death occu	, and due to the cau rred at the time, dat	ise(s) and manne e and place, and	er as stated. due to the cause(s)
ely fillec	dice	(Check only 2 Medical Examone)	and manner stat						
ely fillec	Medical	Check only 2 Medical Exam	and manner stat	4 A	29c. Licens	se number	290	d. Date signed (A	Month, Day, Year)
Funeral ely fillec	Medica	one) 2 Medical Exam	Bes	es out	29c. Licens 63053				
To the Funeral Direction Completely filled in b	Medica	one) 2 Medical Exam	Begin	n	63053				30, 2005

12 128 los 0725 AM

YENSON, Jane

,,,	,0		For State Registrar	State of Marylan	-	artment of H rtificate of L			ene 005	43739
ı	Physici	an	1. Decedent's Name (First, Middle, La Rosalina	st)	Vida	1		2. Date of Death Month	Day Year	3. Time of Death
1	/Medic	al	4a. Fecility Name (If not institution, giv	e street and number)		Ab City Town or	Location of Death	DECEMBER	31, 2005 4c. County of Deat	1700 P M
	Examin	er	PRINCE GEORGES HO			CHEVERLY	COOLIGIT OF DOGIN		PRINCE GE	
Ī	Funeral Director		none	7. Age (In yrs. 4 C		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) 9 / 0 4 / 1	9. Birt. Co 965 HO	nplace (State or Foreign untry) nduraras
	land		Usual Residence of Decedent 10a. State 10b. County		y, Town or Lo	ocation				10d. Inside City Limits
	a-f eh	ctor	MD Prince	George's	Hyatt	sville				1 ☐ Yes 2 No
	th with the 23a or 28	ai Director	10e. Street and Number 8016 18th Aver	nue		10f. Zip Code 2 (783	100	g. Citizen of What Co Honduras	
36	n 72 hours after death with the Maryland "naturel", or Itame 23a or 28a-f ehow udical Examiner must be molified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1		Was Decedent of Hi If Yes, specify Cuba 1 ☑ Yes 2☐ No	spanic Origin? (Sp n, Mexican, Puerto Specity: Hon		14. Race - Ame Black, White Specify: W	
5-0036	2 8 3	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupa kind of work done of			6b. Kind of Business/	
21213	withir than	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life.	eaning S)	i	Cleaning	Company
ō	should be filed ind Mental Hygid marked other umatic event, II	0	17. Father's Name (First, Middle, Last, Eugenio Cardor					e (First, Middle, Ma la Vidal		
, Mar	and 2 sho salth and I n 27 is ma ar treums		19a. Informant's Name/Relationship (Jose Hernande:						City or Town, State, 2	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury of other treumatic events.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif.)	Removal from State	emetery, crei	sition (Name of matory or other place o Rosar	9)	E	oc. Location - City or l Parais Hondura	o Copan,
Balt	permit. Departr Import		21. Signature of Funeral Service Lice	melle "	Př 92	Name and Address HILTP D. 241 Colu	RINALDI mbia Bl	FUNERA	L SERVIC er Sprin	E,P.A. g,Md20910
ı			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	h. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arres	it,	Approximate Interval Between
All or	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	· NULTIPLE	THY.	्रं थे				Onset and Death
ı	Examiner			Due to (or as a conseq	uence of):					
	b sit	lner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consa	uence of):					
•	xecute and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq.	uence of);					
68760,	icate be executed physician and s the burial-transit	edical E		d						
_	ertifica ling ph		IF FEMALE:							
P.O. Box	The law requires that the death certified hes been signed by the attending tage 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
	uires that I signed by Id be deta	٥	Part II. Other significant conditions of	contributing to death but not res	ulting in the u	nderlying cause give	n in Part I.		cco use contribute to	the cause of death?
Seco	e law requir hes been si je 2 should	Completed						24a. Was an autopsy performe	prior to d	topsy findings available ompletion of cause of
a	nysiclan: The law his certificete hes b I director, page 2 s	e Co	25. Was case referred to medical				20 01(D	↑Q Yes 2[□No 142 Yes	2 No
<u> </u>	ysicle iis cert direct	To B	examiner? 1 XYes 2 ☐ No	Hospital: 1 ☐ Inpatient 2X	ER/Outpatier	nt 3□ DOA Othe		n <i>(Check only one)</i> me 5 ☐ Residen	ce 6 ☐ Other (Spec	ufy)
Division of Vital Records,	nding Ph ath. r: Atter th e funeral	ation:	27. Manner of Death 1 □Natural 5 □ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work		28d. Describe how		
Divis	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifice completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	building, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (Stre City or Town,	media a more	ral Route Number,
	he Hospi n 24 hour he Funer sletely filli	edical	29a. Certifier	nysician: To the best of my kno niner: On the basis of examina and manner stated.	wiedge, deati tion and/or in	n occurred at the tim vestigation, in my op	e, date and place.	and due to the cau	se(s) and manner as	stated
	withi To th	ž	29b. Signature and title of certifier	1// 2 2		29c. License		!	d. Date signed (Month	
,	(Muliparte VI	The Thele 1	w		CME	JAI	NUARY 1, 2	UU6
			30. Name and addrest of person who MARY COM A 31. Date filed (Month, Day, Year)	Koreh	111 P	ENN STREE	Γ, BALTIM	ORE, MAR	YLAND, 212	01
	Sta Registi		JAN 04	32. Régistrar's Signa	H A	parte				

Year

14. Race - American Indian, Black. White, etc.

Specify: Black

December 28, 2005

4:40 am M

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1★Yes 2 No

2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** NEILLY WALTOWER December 25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fairland Nursing And Rehab Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Days 1**X** M 2□ F Hours 579-60-6190 Yrs Director 67 Oct. 23, 1938 Georgia Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at Director MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1235 Potomac Valley N.C. 20850 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 □ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify: δ 3 ☐ Widowed 4 T Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be f h end Mental I end Mental Joe Waltower Unknown 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 to Department of Heelth er Important: If item 27 ie any injury or other trau <u>once</u>. Kimberly Edley/Guardian P.O. Box 31550 Washington, DC 20030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crematory Jan. 4,2006 Riverdale, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Johnson and Jenkins Funeral Home 716 Kennedy Street NW Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC CARCINOMA OF NECK /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner anding physiclen and use as the burial-translt Due to (or as a consequence of): P.O. Box 68760. the attending physiclen Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy jo 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No deteched 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Completed

s been signed by the should be detech Division of Vital Records, certificate death. hours efter death completely filled in by the

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

D52261

Silver Spring, MD 20910

24 hours e Funerai I

To the within 2 To the

State Registrar

Be

٩

Certification:

Medical

Alan R. Segal, MD 31. Date filed (Month, Day, Year) JAN 0 4 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



AEM 05-08528 Ovena White

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Yeer **Physician** White Ovena. December 17, 2005 10:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly
If Under 1 Year | If Under 24 Hrs. Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Min 1□ M 21 F Hours December 20, 1957 Washington, D.C. 47 Yrs. 577-76-8697 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow the Medical Examiner must be notified at Yes 2 □ No Director D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20019 U.S.A. 5224 Banks Place, N.E. permit. Pages 1 and 2 should be filed within 72 hours after death v
Depertment of Heelth and Mental Hygiene
Important: If Itam 27 is marked other than "natural", or Itams 23s
any Injury or other traumatic avent, the Medical Examiner must anone. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Unemployed N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eleanor Brown Obediah White ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 3953 Clay Place, N.E. Washington, D.C. 20019 Pamela Tyler-Bodrick (SIster) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition December 31, 2013 c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory, Inc. Beltsville, Md. □ Donation 5 □ Other (Specify) Rolling Funeral Home, Inc. ure of Funeral Service Licensee 22. Name and Address of Facility Signa 4339 Hunt Place, N.E. Washington, D.C. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, effock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician NARCOTIC INTOXICATION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Cualto (or se a donesquanea of) Examine anding physicien and use as the burial-transit or Attanding Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the eld be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 TUnknown peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ∠Yes 2 □ No autopsy performed? NZ)Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Chick only one Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No his nours after death.

neral Diractor: After this
filled in by the funeral d 28b. Time of Injury at M 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes XX No UNKNOWN 2 Accident found 12-17-05 Found 12-17-05 9.40 mm 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
FOUND AT RESIDENCE Y Yould not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5224 BANKS PL.,,SE, WASH.,DC 4 - Homicide To the Hospital o within 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of centrer 29c. License number 29d. Date signed (Month, Day, Year) OCME December 18, 2005 of person who completed cause of death (Item 23a) (Type, Print) NIPPLEND 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 4 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) DECEMBER 21, 2005 **Physician** WINTERS 1:40P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE HYATTSVILLE 1902 BENDER COURT 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2√2 F MARYLAND Director 219-34-7757 Yrs. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-1 show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Ves 2 No Director MD PRINCE GEORGE HYATTSVILLE 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 20785 U.S.A. 1902 BENDER COURT Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0036 1 Yes 2 No þ 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER PRIVATE 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) RUBY ANNA HAWKINS JASE HENRY WINTERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1902 BENDER COURT HYATTSVILLE, MD 20785 ANDREWS WINTERS/SON 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. * 4 ☐ Donation 5 ☐ Other (Specify) 12-29-2005 BRENTWOOD, MD FT. LINCOLN 22. Name and Address of Facility 21. Signature of Funeral Service Licensee JB JENKINS FUNERAL HOME 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CERVICAL CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 4☐Pregnant at time of death P.O. 1 ☐ Yes 2 XNo the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No certificate 2 🗀 No 1 Yes Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🛣 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DQA uneral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) filled in by 4 Homicide 16 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number -dran D23743 January 4, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARTIN D. WELTZ 7525 GREENWAY CENTER DRIVE GREENBELT, MD 20770 31. Date filed (Month, Day, Year) . Registrar's Signature State JAN 0 4 2006 Registrar

		Registrar			Cerunca	ate of Dea	ath	1	Reg. No.		1011
Dharin		1. Decedent's Name (First, Midd	le, Last)					2. Date of Dea		Year	3. Time of Deat
Physicia /Medic		Emma	Wheeler		· · · · · · · · · · · · · · · · · · ·			Decembe	r 27,	2005	12:40a
Examin		4a. Facility Name (If not institution	-		4b. C	ity, Town, or Loca	ation of Death		4c. Coun	ty of Death	
		Prince George				neverly				e Geo	
Funeral		5. Social Security Number	6. Sex 7.	. Age (In yrs. last b	birthday) If Un Monti	hs Days Ho	ours Min.	8. Date of Birt (Month, Da	v, Year)		place (State or For
Director		579-28-3624 Usual Residence of Decedent		87	115.			Sept. 1	,1918	Sout	n Caroli
Mo #		10a. State 10b. County	/	10c. City, To	own or Location					1	0d. Inside City Lin
튭	to	DC		Washi	ington						1 X Yes 2 □
1289	Director	10e. Street and Number		Wabiii		Zip Code			10g. Citizen o	f What Cour	ntry?
3a o		1704 R Street	SE Apt.#1			20020			United	State	25
E E	Funerai	11. Marital Status	12. Was Decede	ent Ever in U.S.	13. Was De	ecedent of Hispan	ic Origin? (Sp	ecify Yes or No	14. R	ace - Americ	an Indian,
or its	F	1 ☐ Never Married 2 ☐ Ma	med 1 ☐ Yes 2	. [XNo			ecity:	Thoun, etc.)	Spec	lack, White,	eic.
Eva	d by	3 XWidowed 4 ☐ Divorce	d Year or Date	es:		2 2410 00			Spec	Blac	ck
net a	Completed	15. Decede (Specify only high	nt's Education est grade completed)	16	(Give kind of	Isual Occupation work done during	most of work	ing	16b. Kind of	Business/In	dustry
hen.	mp	Elementary/Secondary (0-12)	College (1-4		life. DO NO	,					
dygie ther nt, tt		Unknown 17. Father's Name (First, Middle	(ast)	t	Housekee		Mother's Nam	e (First, Middle,	Priv		
ed o	Be	Henry Sprin					Cammie	Moble		207	
nd Me mark metic	2	19a. Informant's Name/Relation	U	19	9b. Mailing Addr	ess (Street and N			~	n State Zin	Code)
th an		Flora Washingto			-	y S. Tru					•
Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural; or iteme 23a or 28e-f show any injury or other treumetic event, the Medical Examination institute notified at ance.		20a. Method of Disposition		20b. Place	of Disposition (/	Name of	_	Date	20c. Location		
t: If i		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (ate	ntery, crematory o	orotherplace) orial Cer	1/3	106	C., 4 + 1	, r.	(n1
artme orten injur	- 1	21. Signature of Funeral Service		A							Maryland
0 0 > 0				7 /-	A 1 0 mm	ander S	Pone	Funeral	Homes	, P.A.	
Depar Impo any ir once		1/110000	111		5538	Marlbon	ro Pike	Forest	ville	Md	0747
ysician Medical		23a. Part1. Enter the disease, shock, or heart failure. Lis Immediate Cales (Final disease or condition resulting in death)	a. Due to (or	used the death. Do	o not enter the n	e and Address of cander S. Amarlbon node of dying, sur	ch as cardiac	or respiratory ar	rest,		Approximate Interval Between
ysician Medical taminer	i Examiner	Immediate Calvse (Final disease or condition	a. E No. Due to (or Due to (or S E	S C	co not enter the more of): 7	node of dying, suc	ch as cardiac	or respiratory ar	rest,		Approximate Interval Between
ysician Medical taminer transit	dicai	Immediate Calve (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. E No. Due to (or Due to (or S E	r as a consequence	co not enter the more of): 7	node of dying, suc	ch as cardiac	or respiratory ar	rest,		Approximate Interval Between
ysician Medical taminer transit	dicai	Immediate Calve (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or Due to (or Due to (or d.	r as a consequence r as a consequence r as a consequence r as a consequence the 2 Fetal death that time of death	to not enter the more of): The of): Control of the office of the offic	c pregnancy	ch as cardiac	or respiratory ar	rest, 5 / 2 / 2 / 2 / 2 / 2 / 2 / 2 / 2 / 2 /		Approximate Interval Between Onset and Death
by the attending physician and ached for use as the burial-transit units and ached for use and ached for use and ached for use and ached for use and ached for units and ached for use and ached for units and ached for use and ached for units ached for units and a	Physician/Medical	Immediate Calvse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to infinited access. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	a. Due to (or b. Due to (or d.	r as a consequence r as a conseq	to not enter the man of the order of): The order of): See of): ath 3 □ Ectopic 5 □ Other	c pregnancy (specify)	ch as cardiac	or respiratory ar	23d. D	Date of deliver	Approximate Interval Between Onset and Death
gned by the attending physician and careful transit to detached for use as the burial-transit	by Physician/Medical	Immediate Calvse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or b. Due to (or d.	r as a consequence r as a conseq	to not enter the man of the order of): The order of): See of): ath 3 □ Ectopic 5 □ Other	c pregnancy (specify)	ch as cardiac	or respiratory ar	23d. D	Date of deliver	Approximate Interval Between Onset and Death Death Onset and Death Onset and Death Onset and Death Onset and D
been signed by the attending physician and included for use as the burial-transit unit of the control of the co	by Physician/Medical	Immediate Calvse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or b. Due to (or d.	r as a consequence r as a conseq	to not enter the man of the order of): The order of): See of): ath 3 □ Ectopic 5 □ Other	c pregnancy (specify)	ch as cardiac	23e. Did to	23d. D	Date of deliver	Approximate Interval Between Onset and Death Death Onset and Death Death Onset and Death Death Death Death Dea
has been signed by the attending physician and initial properties and initial properties and initial properties as the burial-transit.	by Physician/Medical	Immediate Calvse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or b. Due to (or d.	r as a consequence r as a conseq	to not enter the man of the order of): The order of): See of): ath 3 □ Ectopic 5 □ Other	c pregnancy (specify)	ch as cardiac	23e. Did to 1 1	23d. D. A. D. D. A. D. D. A. D. A. D. A. D. A. D. A. D. D. A. D. D. A. D. D. A. D. D. A. D. D. D. D. D. D. D. D. D. D. D. D. D.	Date of deliver Aonth Tribute to the surface of th	Approximate Interval Between Onset and Death Death Onset and D
ate has been signed by the attending physician and initial paying page 2 should be detached for use as the burial-transit.	Physician/Medical	Immediate Calve (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 Yes 2 No 9 Unknown Part II. Other significant condit	a. Due to (or b. Due to (or c. Due to (or d.	r as a consequence r as a conseq	to not enter the man of the order of): The order of): See of): ath 3 □ Ectopic 5 □ Other	c pregnancy (specify)	Part I.	23e. Did to 1 \(\) 24a. Was autop perfor 1 \(\) Yes	23d. D. Months and 24b says and	Date of delivered on the state of the state	Approximate Interval Between Onset and Death Death Onset and D
certiticate has been signed by the attending physician and including includi	o Be Completed by Physician/Medical	Immediate Calvse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or b. Due to (or c. Due to (or d.	ras a consequence ras a conseq	to not enter the man of the order of): The order of): See of): ath 3 Dectopic 5 Other g in the underlying	c pregnancy (specify)	Part I.	23e. Did to 1 24a. Was autop perfor 1 Yes	23d. D. M. Dibacco use co (es 2 Mo an 24b Mo me)	Date of delivered on the state of delivered	Approximate Interval Between Onset and Death Death Onset and D
is certificate has been signed by the attending physician and in page 2 should be detached for use as the burial-transit.	To Be Completed by Physician/Medical	Immediate Calve (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 Yes 2 No 9 Unknown Part II. Other significant condit	a. Due to (or b. Due to (or b. Due to (or c. Due to (or d. Due to (or d. Due to (or d. Due to (or second d. Due to	r as a consequence r as a conseq	co not enter the more of the control	c pregnancy (specify) g cause given in 26. DOA Other: 4	Part I.	23e. Did to 1 \(\) 24a. Was autop perfor 1 \(\) Yes	23d. D. M. Dibacco use co res 2 No an 24b No me) ence 6 0	Date of delivered on the state of delivered	Approximate Interval Between Onset and Death Death Onset and D
After this certiticate has been signed by the attending physician and up positionary director, page 2 should be detached for use as the burial-transit.	To Be Completed by Physician/Medical	Immediate Calve (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 Yes 2 No 9 Unknown Part II. Other significant conditions are conditionally likely	a. Due to (or b. Due to (or b. Due to (or c. Due to (or d. Due to (or d. Due to (or d. Due to (or second d. Due to	r as a consequence r as a conseq	co not enter the management of the orbits of	c pregnancy (specify)	Part I. Place of Deat	23e. Did to 1 24a. Was autoperforment of the control of the contro	23d. D. M. Dibacco use co res 2 No an 24b No me) ence 6 0	Date of delivered on the state of delivered	Approximate Interval Between Onset and Death Death Onset and D
to a state this certificate has been signed by the attending physician and in pays to restrict Attention page 2 should be detached for use as the burial-transit.	To Be Completed by Physician/Medical	Immediate Calve (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 Yes 2 No 9 Unknown Part II. Other significant condit 25. Was case referred to medic examiner? 1 Yes 2 No 27. Man of Death 1 Natural 5 Pend investigations of pendicular conditions of the conditions	a. Due to (or b. Due to (or c. Due to (or d.	r as a consequence r as a conseq	co not enter the more of the original control of the control of th	c pregnancy (specify) g cause given in 26. DOA Other: 4 28c. Injury at Work? 1 □ Yes	Part I. Place of Deat	23e. Did to 1 \(\) 24a. Was autoperforment of the control of the	23d. D. M. Dibacco use co (se 2 No ne) lence 6 0 0 ow injury occurrent and Num	Date of deliver from the found of the following the follow	Approximate Interval Between Onset and Death Death Onset and D
4 hours after death. Funerel Director: After this certiticate has been signed by the attending physician and important process. In process, and it is processed in by the tuneral director, page 2 should be detached for use as the burial-transit.	Certification; To Be Completed by Physician/Medical	Immediate Calve (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1	a. Due to (or b. Due to (or c. Due to (or d.	r as a consequence of as a consequence of pregnancy the 2 petal dearn at time of death or the but not resulting the but not resulting patient 2 ER/C Injury - At home, and the consequence of fining - At home, and the consequence of the conseq	co not enter the more of the more of the control of	c pregnancy (specify) g cause given in 26. DOA Other: 4 28c. Injury at Work? 1 Yes	Part I. Place of Deat Nursing Ho	23e. Did to 1 1 Yes h (Check only o me 5 Resid 28f. Location (S City or Tow	23d. D. No an 24b sy med 2 No ow injury occurrence of the control	Date of deliver Annual Probes of Specification of the Control of t	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset Indiana Onset India
4 hours after death. Funerel Director: After this certiticate has been signed by the attending physician and important process. In process, and it is processed in by the tuneral director, page 2 should be detached for use as the burial-transit.	To Be Completed by Physician/Medical	Immediate Calvse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or b. Due to (or c. Due to (or d.	r as a consequence of as a consequence of pregnancy the 2 petal dearn at time of death or the but not resulting the but not resulting patient 2 ER/C Injury - At home, and the consequence of fining - At home, and the consequence of the conseq	contenter the more of the content of	c pregnancy (specify) c pregnancy (specify) g cause given in 26. DOA Other: Work? 1 Yes tory, office	Part I. Place of Deat Nursing Ho 2 □ No	23e. Did to 1 24a. Was autoperforment of the control of the contro	23d. D. M. Dibacco use co des 2 No an sy med? 2 No owningry occurrent and Numm, State) Citreet and Numm, State) Cause(s) and no date and place 29d. Date sign	Date of deliver Month The bute to the state of the state of deliver Month The bute to the state of the stat	Approximate Interval Between Onset and Death Death Onset and D
titer death. Director: After this certilicate has been signed by the attending physician and in property in by the tuneral director, page 2 should be detached for use as the burial-transit in property.	edical Certification; To Be Completed by Physician/Medical	Immediate Calve (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 Yes 2 No 9 Unknown Part II. Other significant conditions are conditionally likely	a. Due to (or b. Due to (or c. Due to (or d.	r as a consequence of as a consequence of pregnancy the 2 petal dearn at time of death or the but not resulting the but not resulting patient 2 ER/C Injury - At home, and the consequence of fining - At home, and the consequence of the conseq	contenter the more of the content of	c pregnancy (specify) c pregnancy (specify) g cause given in 26. DOA Other: Work? 1 Yes tory, office	Part I. Place of Deat Nursing Ho 2 □ No	23e. Did to 1 24a. Was autoperforment of the control of the contro	23d. D. M. Dibacco use co des 2 No an sy med? 2 No owningry occurrent and Numm, State) Citreet and Numm, State) Cause(s) and no date and place 29d. Date sign	Date of deliver Month The bute to the state of the state of deliver Month The bute to the state of the stat	Approximate Interval Between Onset and Death Death Onset and D
4 hours after death. Funerel Director: After this certiticate has been signed by the attending physician and important process. In process, and it is processed in by the tuneral director, page 2 should be detached for use as the burial-transit.	edical Certification; To Be Completed by Physician/Medical	Immediate Calve (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 Yes 2 No 9 Unknown Part II. Other significant conditions are conditionally likely	a. Due to (or b. Due to (or c. Due to (or d.	r as a consequence of as a consequence of pregnancy the 2 Fetal dearnt at time of death when the but not resulting patient 2 ER/C Injury - At home, and the consequence of fining - At home, and the consequence of the conseq	co not enter the manufacture of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original of the original origina	c pregnancy (specify) c pregnancy (specify) g cause given in 26. DOA Other: Work? 1 Yes tory, office	Part I. Place of Deat Nursing Ho 2 □ No	23e. Did to 1 24a. Was autoperforment of the control of the contro	23d. D. M. Dibacco use co des 2 No an sy med? 2 No owningry occurrent and Numm, State) Citreet and Numm, State) Cause(s) and no date and place 29d. Date sign	Date of deliver Month The bute to the state of the state of deliver Month The bute to the state of the stat	Approximate Interval Between Onset and Death Death Onset and D

WILL 05-0		ΥT	ON WARRENFELTZ Please Type or Print in Black	Ind	elible Ink.	. Ensure All	Copies	Are Legib	ole.
RJ			1- State of Maryland / De State of Maryland / De		rtment of F			4 U U	5 43744
			Negistrar Decedent's Name (First, Middle, Last)	7071	modio or		2. Date of Dea Month	ith Day	3. Time of Death
	Physici /Medic		William Clayton Warrenfel				Decembe	er 27, 2	005 4:12 p. M
	Examin	er	4a. Facility Name (If not institution, give street and number) 12522 Good Intent Road		Keyma	T			ick County
	Funeral Director		5. Social Security Number 212-50-8447 6. Sex 1⊠ M 2□ F 7. Age (In yrs. last birtho	2.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Da) 0ct.15	, 1948	Birthplace (State or Foreign Country) Maryland
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of the county	or Loca	ation				10d. Inside City Limits
	n 72 hours after death with the Marylan "natural", or liems 23s or 28s-f show salical Exercinal bandilled at	ctor	MD Frederick		Keymar				1 ☐ Yes 2X No
	vith th	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of W	
	eath v		12522 Good Intent Rd. 11. Marital Status 12. Was Decedent Ever in U.S.	13 W	2175		cify Yes or No-	U.S.A	- American Indian,
ဟ	after d	Funeral	1 ☐ Never Married 2 ☐ Married 1 🗶 Yes 2 ☐ No			dispanic Origin? (Specan, Mexican, Puerto F	Rican, etc.)		, White, etc.
003	ural', c	d by	3 ☐ Widowed 4 ☐ YDivorced If Yes, Give Year or Dates: 1965-68		□Yes 2 ^M No			Specify:	wnite
15-(n 72 h "natu bolica	iete	(Specify only highest grade completed)	lecede Give ki life. Di	int's Usual Occup ind of work done O NOT use retired	oation during most of workin d)	g	16b. Kind of Bus	iness/Industry
212	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or tleme 23a or 28a-f show ont, the Medical Examinat must be notitied at	Completed	Elementary/Secondary (0·12) College (1·4or 5+) fall	rme	r/contra	ctor		beef &	grain/construc.
pur	s 1 and 2 should be filed within 72 ho I Health and Mental tygiene. Item 27 is marked other than "natur other treumstic event, its Medical	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name			
7	should nd Mer marks matic	2	Joseph Warrenfeltz 19a. Informant's Name/Relationship (Type, Print) 19b. Name/Relationship (Type, Print)	Mailing	Address (Street	Margare and Number or Rural		yn Lesc	
∑	alth ar 27 is a treu					., Frederi		-	
Baltimore, Maryland 21215-0036	0 0			, crema	atory or other plac	ce)	ate		City or Town, State
턡	그 문문을 .		4 Donation 5 Other (Specify) 21. Signature of Funeral Services License		Name and Addre	ion 12/29			ille, MD
Ba	Depe Impo eny l		Mar 7- Blother			dway, Unio		Funeral e, MD 2	
			23a. Part. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.		1	,		1	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Contint gum Due to (or as a consequence of)		rot m	end of	- he	id	
	Examiner		Sequentially list conditions						
	ed salt	miner	f any, leaving to immediate cause. Enter Underlying Cause (Disease or injury	j.					
Ć.	executed in and ial-transit	Exan	that initiated events c. resulting in death) Last Due to (or as a consequence of)):					
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attanding Physician: The law requires that the death certificate be ex within 24 hours effer death. To the Funerel Director: After this certificate hes been signed by the attending physicien is completely filled in by the funeral director, page 2 should be detached for use es the burial.	cal	d						
9 X 6	eath certific attending pl	cian/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy					23d Date	of delivery
B	s death he atte	siciai	in the past 12 months? 1 Yes 2 No 1 Yes 2 No		ctopic pregnancy Other (specify)	· · · · · · · · · · · · · · · · · · ·		Mon	·
Ρ.	that the de ed by the a detached	Physi	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	he unc	derlying cause giv	ren in Part I.	23e. Did to	bacco use contri	bute to the cause of death?
rds	w requires that been signed to should be det	ed by					1□Y	es 2 No :	B Probably 4 Unknown
eco	law re	Completed					24a. Was a autop:	sv l pr	ere autopsy findings available for to completion of cause of
<u>a</u>	siclan: The law s certificete hes l irector, page 2 s							2□ No 1	eath? Yes 2□ No
Zi.	ysiclar is certif directo	To Be	25. Was case referred to medical examiner? XXYes 2 □ No Hospital: 1 □ Inpatient 2 □ ER/Outp	atient	3□ DOA Oth	26. Place of Death			(Specify) At scene
J O	ding Phy h. After thi funeral c		27. Manner of Death 28a. Date of Injury 28b. Tin		28c. Injur Wor			ow injury occurre	
Sio	ttendii death. tor: A the fu	ertification;	2 Accident investigation 12-27-05 Fund		P	Yes 2 XNo	subjec	of sho	
Divi	effer of Direct of in by	ertif	4 Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	0	ot, factory, office	1.	City or Tow	treet and Numbern, State) Trylant Rd.	r or Rural Route Number,
	To the Hospital or Al within 24 hours efter of To the Funerel Direct completely filled in by	edical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, (Check only 2 Medical Examiner: On the basis of examination and/	death (occurred at the tir	me, date and place, a	nd due to the c	ause(s) and man	ner as stated.
	the H thin 24 the F mplete	Medi	one) and manner stated. 29b. Signature and title of certifier		29c. Licens				(Month, Day, Year)
			My Wi, mid		OC		j	December	28, 2005
	MIL		30. Name and address of person who completed cause of death (Item 23a) (Ty	уре, Р	rint) 111 P	enn Street	Balt	imore, M	aryland 21201
	Sta	to	31. Date filed (Month, Day, Year) 32. Registrar's Signature						
	Registr		DEC 3 0 2005 Closur &	16	berte				

		1- State of Maryland / State of Maryland /	-	artment of H		d Mental Hy	giene Reg. No. 0	05	43745
Obvojeje		Decedent's Name (First, Middle, Last)		· -		2. Date of De	Day	Year	3. Time of Death
Physicia /Medic		Rachel P. Washington				Decem		2 200	5 1441 M
Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or)eath	4c. Cou	nty of Death	
	•	Anne Arundel Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last t	hirthday)	Annar	oolis If Under 24	Hrs. 8. Date of Bir		Aru	
Funeral Director		0.1.0	Yrs.	Months Days	Hours A	Aug 20	iy, _{Year)} 5 1.930) Mar	place (State or Foreign Intry) y 1 a n d
		Usual Residence of Decedent			l	11009 2	1.550	, 1101	y Lana
ith the Marylar or 28a-f ehow	- N	10a. State 10b. County 10c. City, To							10d. Inside City Limits
he Mi	ecto	Maryland Anne Arunder Ann	apo:			-			1 TyYes 2 No
If it is in the Maryland filed within 72 hours after death with the Maryland Hygiene. The Hear is it is it is in the intilitied at any it is madical Exact in at the intilitied at any in the madical Exact in at the intilitied at any in the madical Exact in at the intilitied at any in the madical Exact in at the intilitied at any in the madical Exact in at the intilitied at any in the madical Exact in at the intilitied at any in the intilities at any in the intilities at any in the intilities at any in the intilities at any intilities at any intilities at any intilities.	ä	Maryland Anne Arundel Ann 10e. Street and Number 1808 Lincoln Dr. 11. Marital Status 1 Never Married 2 Married Married Proces? 1 Yes 220 No Highes		10f. Zip Code	101		10g. Citizen		intry?
Jeath ms 23	era	11. Marital Status 12. Was Decedent Ever in U.S.	13. V	Vas Decedent of Hi		? (Specify Yes or No	USA - 14. F	Nace - Ameri	ican Indian
affer or liter	Fun	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	i			? (Specify Yes or No uerto Rican, etc.)		llack, White	, etc.
ours a	Q	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1	☐ Yes 2☐XNo	Specify:		Spe	cify: B1	ack
72 h 72 h	Completed	15. Decedent's Education (Specify only highest grade completed) 16	(Give	lent's Usual Occupa	furing most of	working	16b. Kind of	Business/Ir	ndustry
within the n	mpi	Elementary/Secondary (0-12) College (1-4or 5+)		OO NOT use retired	")				
Hygie ther ther the		4th 0	Dc	omestic	18. Mother's	Name (First, Middle	Priv Maiden Sum	ate_	Family
2 should be filed within 72 hours after death with and Mahala Hygiene. B marked other then "natural", or Items 23s eumatic event, the Madical Exactinet statt.	To Be	Daniel Peters				ell Fran		211137	
2 should be and Mental Is marked of sumatic even		19a. Informant's Name/Relationship (Type, Print)	9b. Mailin	g Address (Street a	and Number o	r Rural Route Numb	er, City or Tow	vn, State, Zi	D Code)
ite, wall yitality ZIZIOOOOO 1 and 2 should be filed within 72 hours after death with the Maryla 14 Health and Membal Hygiene. 15 the file marked other then "natural", or Items 23a or 28a-1 ehou other treumatic event, it a Madical Exartified at		James E. Washington(Husband)	180	8 Lincol	ln Dr.	Annapo	lis, N	1d. 2	1401
partiling by Milling be permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tre		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State	of Dispos	sition (Name of natory or other place	e)	Date	20c. Locatio	n - City or T	own, State
Pag ment ant: I		'4 □Donation 5 □Other (Specify) Mary		d Vetera		2-29-05			e, Md.
permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee	W	Name and Address	s of Eacility S	ns Mort	uarv,	P.A.	
0.07.40		Larry G. Lees MO0483	18	21 West	St. A	nnapoli	s. Md.	214	
120		23a. Part1. Enter the disease, or emplications that caused the death. Do shock, or heart failure. List only one cause on each line.	o not ente	er the mode of dying	g, such as car	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
Physician /Medical		resulting in death)		erbatio	~				onset and boatt
Examiner		Due to (or as a consequence	0						
	ē	Sequentially list conditions, if any, reading to immediate	# Oi).	ç i Ş				-	
cuted	Examine	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
e exe		resulting in death) Last Due to (or as a consequence	e of):						
death certificate be executed eath certificate be executed eathending physicien and of for use as the burial-transit	dicai	d							
certific	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy							
eath of attention for up	Physician/Me	in the past 12 months?		Ectopic pregnancy Other (specify)				Date of deliv Month	ery Day Year
. 0 00	ysic	1 Yes 2 No Surregiant at time of death 9 Unknown	3 0	Cities (specify)					
requires that the death cer een signed by the attendin hould be detached for use	by PI	Part II. Other significant conditions contributing to death but not resulting	in the un	iderlying cause give	en in Part I.	23e. Did t	obacco use co	intribute to t	he cause of death?
w requires been sign should be						_ 1 🗆	Yes 2 € No	3 □ Prof	bably 4 \(Unknown
S	ompieted					24a. Was		. Were auto	opsy findings available impletion of cause of
VICAL DEC	Con					perfo	rmed?	death?	2 No
VICION:]	Be	25. Was case referred to medical examiner?		0.1		Death (Check only o	one)		-
Physicien: this certific ral director,	2	1 Inpatient 2 ERVC	Outpatient . Time of		4 Nursin	ng Home 5 Resi			(y)
tending death. tor: After the fune	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year)	Injury	28c. Injury Work M 1 \(\sigma\)	res 2□No	28d. Describe	now injury occ	urred	
Atten r deal sctor	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home,	farm, stre			28f. Location (Street and Nur	nber or Run	al Route Number,
s afte	Certification:	4 Homicide determined building, etc. (Specify)				City or To	vn, State)		
UNISION OF The Hospitel or Attending Physicien: within 24 hours after death as a feet death To the Funerel Director. After this certifical completely filled in by the funeral director, it	edicai (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowled 2 Medicel Examiner: On the basis of examination a and manner stated.	ge, death and/or inv	occurred at the time restigation, in my op	e, date and ploinion, death o	lace, and due to the occurred at the time,	cause(s) and i date and place	nanner as s , and due to	tated. the cause(s)
To the To the To the Comple	Me	29b. Signature and title of certifier		29c. License			29d. Date sign	ned (Month,	Day, Year)
				#5	304	/	12/	22/	5
		30. Name and address of person who completed cause of death (Item 23a	(Type, F 2-0 I	Print) Med	ical-	Parkwas	Anna	PN	ID
Sta	te	31. Date filed (Молth, Day, Year) 62. Registrar's Signature	1-	M.		1	()	1	
Registr	ar	DEC 2 9 2005	8						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 3 Time of Death 1. Decedent's Nama (First, Middle, Last) Month Day Yaer December 28, 2005 **Physician** 1:00 AM Catherine Pauline Westberg /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner Montgomery Layhill Center / Genesis Healthcare Silver Spring If Under 1 Yaar | If Under 24 Hrs. 8. Data of Birth (Month, Day, 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🖾 F 09/23/1932 Yrs 73 Maryland 218-26-7299 Director Usual Rasidanca of Decedent filed within 72 hours after deeth with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1⊠ Yas 2 No Director Maryland Harford Aberdeen 10f. Zip Code 10g. Citizan of What Country? 10e. Street and Number 700 West Bel Air Ave. #118 21001 USA Funeral 13. Was Dacedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Pace - American Indian 12. Was Dacadant Evar in U,S. Armed Forces? 11 Marital Status Black, Whita, atc. 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Datas: 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 2 3 ☐ Widowad 4 Ø Divorced Caucasian Completed 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) 16e, Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elamantary/Secondary (0-12) Collega (1-4or 5+) nd Mentel Hygiene. marked other than MD State Police Dept. 12 Accountant 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be f Depertment of Haalth and Mentel I mportant: If Item 27 ie marked of Stella Grubowski 2 Raymond Kight 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 12400 Rousseau Terr; North Potomac, MD 20878 Raymond Kight / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 ☑ Cramation 3 ☐ Ramoval from Stata Injury or D 1/1/2006 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 22. Nama and Addrass of Facility 21. Signature of Funeral Sarvice Licensee Simple Tribute Funeral and Cremation Center 1040 Rockville Pike; Rockville, MD 20850 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onsat and Death **Physician** Immediata Ceuse (Final disaasa or condition rasulting in death) /Medical Urosepsis Examiner Due to (or es a consaguance of): Examiner The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immadiate causa. Entar Undarlying Causa (Disaasa or injury that initiated avents Due to (or es a consaguence of): and Division of Vital Records, P.O. Box 68760. ettending physicien I for use es the burla Physician/Medical Dua to (or as a consequence of): rasulting in daath) Last signed by the et d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 2 24b. Ware autopsy findings available prior to complation of causa of daath? 24a. Was an autopsy parformed? Completed cartificate has 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No funeral director, Be 25. Was casa rafarred to medical 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4☑ Nursing Homa 5☐ Residence 6 ☐ Othar (Specify) 1 ☐ Yes 2⊠ No Certification: To this 28e. Dete of Injury (Month, Day Year) 27. Mennar of Deeth 28b. Tima of 28d. Describe how injury occurred 1 Naturel 5 Panding Injury 4 hours after death.

-unerel Director: After ally filled in by the fur 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Plece of Injury - At home, farm, straat, factory, office building, atc. (Specify) 4 ☐ Homicide Hospital or To the Hospital within 24 hours of To the Funeral 1⊠ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end manner es steted.
2□ Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) 29a. Cartifier edicai (Check only one) and manner stated. 29b. Signature and titla of certifier 29d. Data signad (Month, Day, Year) 29c. License number D53642 12/29/2005

10

DHMH 16 Rev 6/95

State Registrar 5601 Loch Raven Blvd. #303; Baltimore, Maryland 21239

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

32 Registrar's Signature

Xiao Ming Zhou, M.D.

31. Data filed (Month, Day, Year)

04

		•	1 - For State Registrar		State of N	naryland / I		artment of F rtificate of	Health and M <i>Death</i>		leg. No.) [13/4/
25 K	Dhuoisi		1. Decedent's Name (First, A	Aiddle, Las	t)					2. Date of Dea Month		ear _	3. Time of Death
	Physici /Medic		Robert L.							ilec.	30 200	05	1915 M
d.	Examin	er	4a. Facility Name (If not insti	tution, give	street and numbe	21 Park	/	4b. City, Town, o	or Location of Death		4c. County of	Death OMIC	
	Funeral		5. Sociał Security Number	6. Se		Age (In yrs. last bi	rthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1		ace (State or Foreign
2	Director		221-26-4036		X]M 2□F	64	Yrs.	Months Days	Hours Min.	8-1-194	(1°°') Wa	shi	ngton D.C.
	land Sw		Usual Residence of Deceder 10a. State 10b. Co			10c. City, Tow	vn or Lo	ocation				10	Od. Inside City Limits
	Mary Indi	ğΙ	elaware Sus	ssex		Laure	1						M☐Yes 2☐No
	or 288	Jirec	Delaware Sus					10f. Zip Code		1	log. Citizen of Wha	at Coun	ry?
	ath w	rai	100 11000 001	Stre				19956			U.S.A.		
	Hemi Hemi	Funerai	11. Marital Status 1 □ Never Married 2 2	Married	12. Was Deceder Armed Forces 1X Yes 2	s?	13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Black,	White, e	
036	72 hours after death with the Maryland naturel', or iteme 23e or 28e-f show dical Examiner must be notified at	þ	3 ☐ Widowed 4 ☐ Dive		If Yes Give	: 1960–66	,	1 ☐ Yes 🌠 No	Specify:		Specify:	Whit	:e
21215-0036	be filed within 72 hours after death with the Marylar tal Hygliene. Id other than "naturel", or items 23a or 28a-f show other than "naturel", or items from the motified at	Completed	15. Dec (Specify only I	edent's Ed	lucation de completed)	16a	(Give	dent's Usual Occup kind of work done	during most of work	ing	16b. Kind of Busin	ness/Ind	ustry
121	within ene. than "	idmo	Elementary/Secondary (0-	12)	College (1-4o	r 5+)		<i>DO NOT use retired</i> rgeant Su	•		Da 1	0+-	h - D-1!
	inould be filed within the Mental Hygiene. merked other them metic event, the Mental the	Be Co	17. Father's Name (First, Mi	ddle, Last)			be	igeant st	18. Mother's Name			Sta	te Police
'lan	Mental Merital Brked o	To B	William R. W	lest					Wanda I	Lewis			
Maryland	2 should and Mer Is marks aumatic		19a. Informant's Name/Rela	tionship (7	Type, Print)	198	b. Maili	ng Address (Street	and Number or Run	al Route Number	r, City or Town, St	ate, Zip	Code)
	s 1 and 2 should f Health and Mer Item 27 Is marks other traumatic		Lois West (w	ife)		20h Place	06	West 6th	Street La	urel, D	e. 19956 20c. Location - Ci	h, or To	um Stata
nor	90 = 5		1 ⊠ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth			cemete	ary, crei	matory or other place	ce) Cem. Jan.4		Millsbor	•	
Baltimore,	artra artra orta		21. Signature of Funeral Se						ess of Facility Har				
ä	Dep Imp		Hope is	nort	- Hanr	Capair	17	00 West S	treet Lau	rel. De	. 19956	naro	on r.H.
1			23a. Part1. Enter the disease shock, or heart dilure.	e, or comp List only	olications that caus one cause on each	ed the death. Do	not en	er the mode of dyir	ng, such as cardiac	or respiratory arr	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_	a	ronz	VL	1 AR	TERY	Dige	ase		Oliset and Death
	Examiner				Due to (or a	as a consequence	of):—	in FAL	TERY LUPE Uboli	-,			
	No. it	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	•	Due to (or a	as a consequence	of):	9 1/10	, , ,				
	acuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1	· Pu	Inons	2/	1 Eu	n poli	SM			
60,	be exe		resulting in death) cast		Ve	as a consequence	of):	212 P-	- Fol	1/1/2	etion		
68760,	rtificate be executed ng physician and as the burial-transit	edicai		_	d				-				
Box	attending for use a	M/UE	IF FEMALE: 23b. Was decedent pregnar	11.	23c. If yes, outcom	ne of pregnancy 2 Fetal deati	h 3[Ectopic pregnancy	v		23d. Date of		•
	The law requires that the death certate has been signed by the attendin	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			at time of death		Other (specify)	,		Month		Day Year
P.0	that the died by the detached	Phy	Part II. Other significant co	nditions o	ontributing to death	but not resulting	in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use contribu	ute to the	e cause of death?
Records,	ures n sign	d by	Lung	C2	ancei	P				1 🗆 Y	es 2□No 3	☐ Proba	ably 4 Unknown
CO	aw require s been si 2 should 1	Completed	Newt	Vo	penis	2				24a. Was a	n 24b. We	re autop	sy findings available
- R	The lav ate has page 2	Com	Atrial	F	IBRILL	ATION	U,	Flu	H=R	autops perfore	med? dea	th? Yes	
/ita	ician: sertific setor,	Be	25. Was case referred to me examiner?	odical					26. Place of Deat				
of Vital	Physician: r this certifica ral director, I	. To	1 Yes 2X No 27. Manner of Death		Hospital: 1 Nnpa 28a. Date of Ir	itient 2 ER/O	utpatie	IL 3LI DOA	-		ence 6 Other	(Specify)
ion	nding th. :: Afte e fune	ation	1X Natural 5 □ P	ending vestigation	(Month, L	Day Year)	Injury	Wor	rk? Yes 2 □ No		,		
Division	r Atte	Certification:	3 ☐ Suicide 6 ☐ C	ould not be etermined	288. Place of	Injury - At home, f etc. (Specify)	arm, st	reet, factory, office		28f. Location (S. City or Town	treet and Number n, State)	or Rural	Route Number,
	oltal o urs aft oral Di					4 - 40							
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical				of examination a			me, date and place, opinion, death occur				
_	To the To the Comple	Me	29b. Signature and title of c	ertifier				29c. Licens	_	2	29d. Date signed (i	Month, L	Day, Year)
	K. 2		1,0	AU	0			02	29283	3	1 -	1	- 2006
	3.0		30. Name and address of pe					Print)	Muli	1 MA			
la e	Sta	ate.	JIMMY Tay, 31. Date filed (Month, Day,	** /	1.9, 1: 32. Regis	45 E. C strar's Signature	411	01/51.	SAUSSUN	7 /// ()			
*	Regist		JAN		197	eur. K.		Coast 1					

DHMH 17 Rev 1/2001

West, Rebert 6 221-36-4036

			- For Amend Items State of Death Amend Items State of Death Amend Items State Registrar Certificate of Death Reg. No. 05 43748
	Physicia /Medic		. Decedent's Name (First, Middle, Last) Juanita Hayes Allen 2. Date of Death Month Day Year / 2005 / 6.32 M
	Examin		a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A
ľ	Funeral Director		Social Security Number 6. Sex 12-40-0491 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months) 12-40-0491 13-40-
	show	or.	MD N/A Baltimore 10d. Inside City Limits Baltimore 10d. Inside City Limits
	ath with the Marylan 23e or 28e-f show	Direct	10e. Street and Number 901 Cherryhill Road, Apt. 268 10f. Zip Code 10g. Citizen of What Country? USA
	72 hours after death with the Maryland neturel', or Items 23e or 28e-f show lites Enaturel's and buruffied at	Funeral Director	12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Married 2 Married 1 1 Yes 2 No 1 Never Married 2 Married 1 Yes 2 No 1 Never Married 2 Married 1 Yes 2 No No No No No No No
215-0036	2 hours at eturel', or	by	3 XWidowed 4 □ Divorced If Yes, Give □ 1 □ Yes 2 XNo Specify: Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
	within ene. than "	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) 6 (Give kind of work done during most of working life. DO NOT use retired) Nursing Assistant Hospital
Maryland 2	uld be filed Aental Hygi rked other tic event, i	To Be C	17. Father's Name (First, Middle, Last) Charles Hayes 18. Mother's Name (First, Middle, Maiden Sumame) Elsie Barmer
_	and 2 should leadth and Men n 27 is marke		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Star J. Branch, daughter 8 Cinnamon Circle, Ant. 3-A Randallstown, MD 21133
altimore,	of He		20a. Method of Disposition 1 Grand Burial 2 X Cremation 3 Grand from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Baltimore, MD
Balti	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licensee George MacNabh 22. Name and Address of Facility Cremation Society of MD, Inc.
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
1	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Large medical corebral artery infarct Due to (or as a consequence of): athleros: Cleros: Sequentially list conditions.
	uted d ansit	Examiner	if any, leading to immediate Due to (or as a consequence or):
>,09789	ificate be executed g physician and as the burial-transit	edical Exa	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d. CERTIFICATION APPROVED BY MEDICAL EXAMINER DEFENALS:
XO	death certifica e attending ph d for use as th		23c. If yes, outcome of pregnancy 10 ive birth 2 Deats death 3 Decreases: 23d. Date of delivery
P.O. B	0 0 2	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown Unk
	The law requires that the tte has been signed by thoage 2 should be detache	by	Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Vital Records,	The law re ate has be page 2 sho	Completed	HYDETHEUSION, apper gastooinlestinal blease yes 2/No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2/No 1/Yes 2/No
	Physicien: The this certificate al director, pages	To Be C	25. Was case referred to medical examiner? 1 X Yes 2 100
Division of	of or Attending Phater death. I Director: After the in by the funeral		27. Manner of eath 1
DIVIS	Hospitel or Attending Physicien: 4 hours after death. Funerel Director: After this certificately filled in by the funeral director,	Certification:	3 Suicide 4 Homicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) at home 28f. Location (Street and Number or Rural Route Number. MD) City or Town, State) 901 Cherry Hill Rd., Baltimore,
	To the Hospitel within 24 hours a To the Funeral I completely filled	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
į	vith To	Σ	29b. Signature and title of certifier Res 000 12/4/05
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DW. Fr. SOUZCIAL nitski. 5601 Loch Raven BLVd, Baltimore, MD, 21239
44	Sta Regist		31. Date filed (Month, Day, Year) DEC 0 6 2005 32. Egistrar's Signature

	2. Date of Death	3. Time	of Death	1
Certificate of Death	Reg. No. CUUD	43	14	9
repartment of Health and N	nerital riggiciton of m	1 0	n-2 7	0

Physician
/Medical
Examiner
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23s or 28a-f ehow any injury or other treumatic event, the Mexical Examinational Examination and place.

To Be Completed by Funeral Director

Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland

Baltimore, Maryland 21215-0036

Physician /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner

within 24 hours efter death. To the Funeral Director: After this certificate has been signed by the attending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

1 - State Registrar		Ce	ertificate of	Death	R	g. No.	05 43749
1. Decedent's Name (First, Middle, La	ast)		*******		2. Date of Deat Month	h Day	3. Time of Death
JAMES EARL ART	[S					27. 200	- M
4a. Facility Name (If not institution, gi			4b. City, Town, o		eath	4c. County PRIN	of Death ICE GEORGES
6801 CLINTON MAN 5. Social Security Number 6.		In yrs. last birthda	CLINIC	If Under 24 h	Hrs. 8. Date of Birth		Birthplace (State or Foreign
	XXX M 2□F	63 Yrs.	Months Days	Hours M	JAN. 26		Country)
Usual Residence of Decedent		0.5			JAN. 20	1942	WASHINGTON, DO
10a. State 10b. County	1	IOc. City, Town or I	Location				10d. Inside City Limits
MD PRINCE	GEORGES	CAPITOL	HEIGHTS				XiX Yes 2 No
10e. Street and Number			10f. Zip Code		1	0g. Citizen of \	What Country?
504 VALLEY PARK				20743			D STATES
11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13	 Was Decedent of F If Yes, specify Cubi 	lispanic Origin? an, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)		ce - American Indian, ck, White, etc.
XX Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes XX No If Yes, Give Year or Dates:		1 ☐ Yes XXX No	Specify:		Specify	y: BLACK
15. Decedent's E (Specify only highest g	Education rade completed)	(Giv	edent's Usual Occup re kind of work done	during most of	working	16b. Kind of B	usiness/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire				
10TH 17. Father's Name (First, Middle, Las		S	ECURITY G		Name (First, Middle, M		RIVATE
HENRY J.B. ARTIS	,				REID		,
19a. Informant's Name/Relationship		19b. Ma	ilina Address (Street		RELD Rural Route Number	City or Town.	State, Zip Code)
ALMA BELL / SIST	1		VALLEY PA				
20a. Method of Disposition	LEK	20b. Place of Dis	position (Name of				TS MD 20743 - City or Town, State
XXBurial 2 ☐ Cremation 3 if 4 ☐ Donation 5 ☐ Other (Spec		•	ematory or other place		7.177.06		
21. Signature of Funeral Service Lice			CTION CEME 22. Name and Addre		JAN 06	CLINT	ON, MD
V Pm	080		MARSHALI	'S FUN	ERAL HOME		
23a. Part Enter the disease, or cor	nplications that caused th	ne death. Do not e			ROAD SUITL diac or respiratory arre		Approximate
show or heart failure. List only	••						Interval Between Onset and Death
disease or condition resulting in death)	a. Hypothermia	a consequence of):					
	Due to to as a t	consequence on.					
Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):					
Cause (Disease or injury that initiated events							
resulting in death) Last	Due to (or as a	consequence of):					
	d						
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		B⊟Ectopic pregnancy	,			te of delivery
in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at tir 9☐ Unknown		Other (specify)			Mo	onth Day Year
9 Unknown							
Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause giv	en in Part I.			tribute to the cause of death?
Schizophrenia					_ 1 □ Y€	s 2 No	3 ☐ Probably 4 ☐ Unknown
					24a. Was a autops	n 24b.	Were autopsy findings available plor to completion of cause of
					y perform	ned? 2 ☐ No	1 Z Yes 2 No
25. Was case referred to medical examiner?				26. Place of	Death Check only on		
1 XYes 2 □ No	Hospital: 1 ☐ Inpatient			er: 4 🗆 Nursin	g Home 5 🗆 Reside	nce 6XX Oth	ner (Specify) AT SCENE
27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day)	Year) 28b. Time	of Find 28c. Injur	y at k?	28d. Describe ho	w injury occur	
2 X Accident investigation	12/21/03	4:27 A		Yes XX No	environme	ntal tem	perature
3 Suicide 6 Could not 4 Homicide determine	d 28e. Place of Injury building, etc.	/ - At home, farm, : (Specify)	street, factory, office		28f. Location (St City or Town	reet and Numb , State) 620	per or Rural Route Number, 1 Clinton Manor Dr.
	Found outsi				Clinton, M	_	- CITICAL IEROI DI
(Check only 2 Medical Exa	Physician: To the best of aminer: On the basis of e	xamination and/or	ath occurred at the til	ne, date and pl pinion, death o	ace, and due to the ca	ause(s) and ma	anner as stated. and due to the cause(s)
one) 21	and manner state	d.					

State Registrar

JAN 1 9 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



29c. License number

O.C.M.E

111 PENN STREET, BALTIMORE, MARYLAND 21201

29d. Date signed (Month, Day, Year)

27, 2005

DEC.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 20a-c 22 per file 853 3-29-06 yt.

State of Maryland Department of Health and Mental Hygiene

For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** December 5:14 PM M 24, 2005 Raymond Asner /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 621 N. Potomac Street Baltimore If Under 1 Year | If Under 24 Hrs. Birthpface (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 ☑ M 2 □ F Yrs. Feb 8, Maryland 213-01-5127 86 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Item 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be recitled at 1√2 Yes 2 □ No Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 21205 USA 621 N. Potomac Street death v Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status liled within 72 hours after 1 Never Married 2 ☐ Married 1 □ Yes 2 ☑ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1☐ Yes 2∏ No Specify Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 0 insurance agent insurance 18. Mother's Name (First, Middle, Maiden Sumame) unk 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental I it of Health and Menta ပ John Asner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk 19a. Informant's Name/Relationship (Type, Print) Dept of Aging/Artie Shaw 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Mt. Carmel Cemetery 3-29-06 Baltimore, Md. 4 □Donation 5 □Other (Specify) in state 2829 Hudson St. reet 22 Na**Skarda**s**funeval** State Anatomy Boar 21. Signature of Funeral Service Licensee Ronald S. Wade 21201 esson r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Baltimore, MD Approximate Interval Between Onset and Death 23a. Part1. Duter the disease, in complications that caused the shock, on leart failure. List only one cause on each line. Immediate Cau e (Final disease or condition resulting in death) 5 MINUTE Physician ARRHY THMIN /Medical Due to (or as a consequence of): Examiner MEUMONIA Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed transit and Due to (or as a consequence of): attending physicien a for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 TEctopic pregnancy 1 Live birth Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, ed bluods 2 X No 3 ☐ Probably 4 ☐ Unknown DISEASE, CEREBROVASCULAR Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CARDIOMYOPATH autopsy performed? res 2 No has page HYPERTENSICA 2 \(\text{No} \) certificate 1 Yes Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTED LIVING 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 2 this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) FACILIT Certification; After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel pen j 🗽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 00062032 JANUARY 2006 16 30. Name and address of person who completed cluse of death (Item 23a) (Type, Print) GO STHERRING BAHULEVI CIRCLE CHA FER HATYASH

Registrar

State

31. Date filed (Month, Day, Year) JAN 1 8 2006

30 E

2. Registrar's Signature

		•	1 - State Amend Items Registrar Amend Item	State of Maryland 23a, PtI, II, 2 1 per ME, G851,	1/Department of H 5/27/28a-f. per ,01/19/06alsbot L	ealth and Mental Hy ME, G851, 01/18/0 Death	diene Dedhb 005 Reg. No.	43751
	Physicia /Medic		 Decedent's Name (First, Middle, Last) 	BISSER	SR.	2. Date of D. Month Novem	eath Day Year	3. Time of Death 5: 23 P M
) F.	Examin		4a. Facility Name (If not institution, give	1 /	4b. City, Town, or BALTIA	Location of Death	4c. County of Deat	h
	Funeral Director		5. Social Security Number 6. Sec			If Under 24 Hrs. 8. Date of Bi	ay, Year) Co	hplace (State or Foreign untry) ARY LAND
	D		Usual Residence of Decedent 10a. State 10b. County	10c. City,	, Town or Location			10d. Inside City Limits
	e Mary Ba-1 sh diffed	Director	MD.	BF	ALTIMORE			1 Yes 2 No
	with th		10e. Street and Number 4610 VIRGINIA	AUE	10f. Zip Code	_	10g. Citizen of What Co	untry?
	r death	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	6. 13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Specify Yes or N n, Mexican, Puerto Rican, etc.)		
5-0036	72 hours after death with the Maryland natural", or Itams 23c or 28a-1 show iteal Eraminat must be indiffed at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Pres 2 No If Yes, Give Year or Dates: 1962	1 ☐ Yes 2 12 No	Specify:		HITE
215-0	i within 72 hours after death with the Marylan liene rthan "natural", or litams 23c or 28a-1 show tha Medical Examinar mast be multified at	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired,	during most of working	16b. Kind of Business/	industry
7		Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	CORRECTIONAL			NITENTIARY
and	be day	o Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle MARIE	e, Maiden Sumame) MARO	CRAE
Maryland	2 sho and Is m	F	19a. Informant's Name/Relationship (T)	SSEIL rpe, Print)	19b. Mailing Address (Street a	and Number or Rural Route Num		
	1 and Heali tam 2		JOANN WILLIS 20a. Method of Disposition	20b. Pla	4610 VIRGIN ace of Disposition (Name of	Date	20c. Location - City or	QIA35 Town, State
altimore,	Page: nent o ant: If ury or		1 Burial 2 Cremation 3	temoval from State	ometery, crematory or other place	Nov. 22 2605	Baltimor	E Md.
Balt	permit. Pag Department Important: I any injury c once.		21. Signature of Funeral Service Licens	men seem li	22. Name and Addres	of Facility General F	ILIMORE MA	2016 P.A.
	· ·		23a. Part1. Enter the disease or comp shock, or heart failure List only o	ications that caused the death.		g, such as cardiac or respiratory	arrest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- Congestive	Heart Fa	ve Atheroscler	1	Onset and Death
	Examiner	_	Sequentially list conditions, if any, leading to immediate	Subdura	d Hematon	Cardiovascu		18 days
	d d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	ence ot):	1/1/21		-
60,	ficate be executed physician and is the burial-transit		resulting in death) Last	Due to (or as a consequ	ence of):	CERTIFICATION APPROVED I	BY MEDICAL EXAMINER	
68760,	# C0 65	ledical		d		CERTITION		
.O. Box	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3 Ectopic pregnancy		23d. Date of deli Month	ivery Day Year
٥	res that the de igned by the a be detached t	by	Part II. Other significant conditions co		Ilting in the underlying cause give		tobacco use contribute to	
corc	w requir s been s should	leted	Diabata	4 - 11	Subdural hemat			itopsy findings available
of Vital Records,		Completed	is table jes.	T Certa y		auto	formed? death?	completion of cause of
Vita	Physiclan: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner?	Hospital:	ER/Outpatient 3 □ DOA Othe	26. Place of Death (Check only		cifu)
	ding Phys h. After this funeral di		27. Manner of Death SNatural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury North	y at 28d. Describe	how injury occurred	onyy
Division	Atten r deat ector: by the	Certification;	2 X Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	10/28/2005 28e. Place of Injury - At hor	Unknowth 1□1 me, farm, street, factory, office t)		Ct fell (Street and Number or Ru own State) HOSPOITAL (A	ıral Route Number,
	Hospital or Attand 14 hours after death 5unaral Director: tely filled in by the			at hospita	<u>I</u>			
	00 0 2	l a				ne, date and place, and due to the pinion, death occurred at the time		Stated.
	the Ho: iin 24 h tha Fur pletely	edi						to the cause(s)
	To the Hospital or Attenvillo 24 hours after deat to the Funaral Director:	Medical	29b. Signature and title of certifier		29c. License		29d. Date signed (Month	h, Day, Year)
(6	vithin 24 h	Medi	29b. Signature and title of certifier	ng Sim	RE	5000	November 1	h, Day, Year)
(t	Vithin 24 h		29b. Signature and title of certifier	ng Sim	RE	5000	November 1	h, Day, Year)

40 S - 12	ian	1. Decedent's Name (First, Middle,		1309	TON		Date of Death Month	Day 3 Year	3. Time of Death
/Medi Examii		4a. Facility Name (If not institution,			4b. City, Town, or Loc		1000-151)-	4c. County of Deat	(33)
			OSPITAL		BALTIMORE			N	A
Funeral Director		5. Social Security Number 213 - 18 - 1510	5. Sex 7. Age (In y	rrs. last birthday) Yrs.	If Under 1 Year If I Months Days H	Under 24 Hrs. 8. ours Min.	Date of Birth (Month, Day, Ye 2 · 24 · 9	9. Birt 62	hplace (State or Fore
		Usual Residence of Decedent				12	<u></u>	99	
f shov	ō	10a. State 10b. County		City, Town or Lo					10d. Inside City Limi 1 X Yes 2 ☐ N
tal Hygiene. d other then "natural", or teams 23s or 28s-f show event, the Mydical Exerting must be notitled at	Funeral Director	10e. Street and Number	LN OF	THORE	10f. Zip Code		10g.	Citizen of What Co	untry?
a 23a o	raiD		VENUE		21216			USA	
ritem	Fune	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Ever in Armed Forces? d 1 ☐ Yes 2 🔯 No	1 U.S. 13.	Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Specify exican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Ame Black, White	rican Indian, e, etc.
Eyan	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1⊡Yes 2⊠ENo Sp	pecify:		Specify: B	ACK
"natu	Completed	15. Decedent's (Specify only highest	Education grade completed)	(Give	dent's Usual Occupation kind of work done during DO NOT use retired)	g most of working	166	. Kind of Business/	Industry
r than	d Ho	Elementary/Secondary (0-12)	College (1-4or 5+)	me.	N A			NA	
othe rent,	Be C	17. Father's Name (First, Middle, La	· · · · · · · · · · · · · · · · · · ·			Mother's Name (F	irst, Middle, Mai	den Sumame)	
Menta varked	To	JOHN BOSTON					ILLIAMS		
th and 27 Is rr traurr		19a. Informant's Name/Relationshi COLLEEN BOSTON	р (Турө, Print)	-1-	ng Address <i>(Street and I</i> 1ARKSWORTH			ity or Town, State, 2 21228	Zip Code)
f Heal Item 2		20a. Method of Disposition		. Place of Dispo		Date		Location - City or	Town, State
nent o ant: K ury or		1 Burial 2 □ Cremation 3	3 □Removal from State At	RBUIUS	matory of other place)	11-11-05	5 BA	LTIMIORE	, MD
Department of Health and Mental Hygiene. Important: for Itama 23a or 28a-1 show Important: if Item 27 is marked other than "natural", or Itama 23a or 28a-1 show any injury or other traumatic event, the Medical Exartment must be notified at once.		21. Signature of Funeral Service Li	censes	VA 51	Name and Address of NUGHN C. GRI	Facility EENE FUN 7 PILE BO	ERAL SEA	211229	
Nedures that the death certificate be executed the law requires that the death of the attending physician and page 2 should be detached for use as the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a cons	sequence of):	James	in /	,		
ician and burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons	nort I	0 = \$70	Mar	COAD-Y	CAMINER	
hysician the buria	ical	that initiated events	c. Due to (or as a cons	nort I	01- 570-	MAN APPROVE	ED BY MEDICAL E	CAMINER	
attending p for use as	ical	that initiated events	c. Due to (or as a cons d. 23c. If yes, outcome of pret 1 Live birth 2 F 4 Pregnant at time of	sequence of): gnancy etal death 3	CERT Dectopic pregnancy Other (specify)	MAN APPROVE	ED BY MEDICAL E	23d. Date of delimenth	very Day Year
gned by the attending poeded by the attending poeded for use as	Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2♥No	d	gnancy etal death 3 [f death 5 [Ectopic pregnancy Other (specify)	TON APPRO		23d. Date of deli Month	,
gned by the attending p se detached for use as	by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant condition	d	gnancy etal death 3 [f death 5 [Ectopic pregnancy Other (specify)	TON APPRO		23d. Date of deli Month	Day Year the cause of death?
ite has been signed by the attending p vage 2 should be detached for use as	Physician/Medical	Gause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant condition Monthly Seizur	d	gnancy etal death 3 [f death 5 [Ectopic pregnancy Other (specify)	TON APPRO	23e. Did tobacc	23d. Date of deliment Month co use contribute to 2 No 3 Pro 24b. Were au prior to content of content or cont	Day Year the cause of death? bbably 4 ☐Unknow
ite has been signed by the attending p vage 2 should be detached for use as	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition Manual Failure, seizur 25. Was case referred to medical examiner?	23c. If yes, outcome of pred 1 Live birth 2 Fe 4 Pregnant at time of your unknown secontributing to death but not reconstructions of the disorder	gnancy etal death 3 condens of death 5 condens of conde	Dectopic pregnancy Other (specify) Inderlying cause given in tive heart 26.	Part I. Place of Death (C.	23e. Did tobacc 1 Yes 24a. Was an autopsy performed 1 Yes 2 heck only one)	23d. Date of deliment of the second of the s	Day Year the cause of death? bbably 4 Unknov topsy findings availate completion of cause of
n. After this certificate has been signed by the attending p funeral director, page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition **Tailure, seizur** 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	23c. If yes, outcome of pret 1 Live birth 2 F. 4 Pregnant at time of 9 Unknown s contributing to death but not reached a contributing to death but not reached a contributing to death but not reached a contributing to death but not reached a contributing to death but not reached a contributing to death but not reached a contribution of the contr	gnancy etal death 3 cresulting in the unit Conges	Dectopic pregnancy Other (specify) Inderlying cause given in Itive heart 26. t 3 DOA Other: 4 28c. Injury at Work?	Part I. Place of Death (C.	23e. Did tobacc 1 Yes 24a. Was an autopsy performed 1 Yes 2 heck only one)	23d. Date of deliment of the second s	Day Year the cause of death? bbably 4 Unknow topsy findings availab completion of cause of
n. After this certificate has been signed by the attending p funeral director, page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition **Tailure, seizur* 25. Was case referred to medical examiner? **Yes 2 No 27. Manner of Death	23c. If yes, outcome of pred 1	gnancy etal death 3 cresulting in the unit conges ER/Outpatien 28b. Time of Injury	Dectopic pregnancy Other (specify) Inderlying cause given in tive heart 26. t 3 DOA Other: 4 28c. Injury at Work? M 1 Yes	Part I. Place of Death (C. Nursing Home 28d.	23e. Did tobacc 1 Yes 24a. Was an autopsy performed 1 Yes 2 heck only one) 5 Residence Describe how in	23d. Date of deliment of the second of the s	Day Year the cause of death? bbably 4 □Unknow topsy findings availab completion of cause of 2 □ No
n. After this certificate has been signed by the attending p funeral director, page 2 should be detached for use as	Certification; To Be Completed by Physician/Medical	Gause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition **The Condition of the Cond	23c. If yes, outcome of pretable by the birth 2 F. 4 Pregnant at time of 9 Unknown s contributing to death but not reconstruction Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	gnancy etal death of death Conges EP/Outpatien 28b. Time of Injury t home, farm, stre converge, death	26. t 3 DOA Other: 4 28c. Injury at Work? M 1 Yes eet, factory, office	Part I. Place of Death (C. Nursing Home 28d. 2 No 28f.	23e. Did tobacc 1 Yes 24a. Was an autopsy performed 1 Yes 2 Deck only one) 5 Residence Describe how in Location (Street City or Town, Sidue to the cause	23d. Date of deliment of the last of the l	Day Year the cause of death? bbably 4 □Unknow topsy findings availab completion of cause of 2 □ No
n. After this certificate has been signed by the attending p funeral director, page 2 should be detached for use as	To Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pred 1	gnancy etal death of death Conges EP/Outpatien 28b. Time of Injury t home, farm, stre converge, death	26. t 3 DOA Other: 4 28c. Injury at Work? M 1 Yes eet, factory, office	Part I. Place of Death (C. Nursing Home 28d. 2 No 28f. ate and place, and h, death occurred a	23e. Did tobacc 1 Yes 24a. Was an autopsy performed to the cause to the cause it the time, date	23d. Date of deliment of the last of the l	Day Year the cause of death? bbably 4 □Unknow topsy findings availab completion of cause of 2 □ No ral Route Number, stated, to the cause(s)
fler death. Director: After this certificate has been signed by the attending p in by the funeral director, page 2 should be detached for use as	edical Certification; To Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pred 1	gnancy etal death of death Conges EP/Outpatien 28b. Time of Injury t home, farm, stre converge, death	26. t 3 DOA Other: 4 28c. Injury at Work? M 1 Yes eet, factory, office	Part I. Place of Death (C. Nursing Home 28d. 2 No 28f. ate and place, and h, death occurred a	23e. Did tobacc 1 Yes 24a. Was an autopsy performed to the cause to the cause it the time, date	23d. Date of deliment of the second s	Day Year the cause of death? bbably 4 □Unknow topsy findings availab completion of cause of 2 □ No ral Route Number, stated, to the cause(s)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) DECEMBER 30, 2005 **Physician** 8:33 А м George Franklin Brackett /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 9005 CHELTENHAM AVE CLINTON PRINCE GEORGES CO If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign Country) Virginia 7. Age (In yrs. last birthday) **Funeral** 1 XM 2□ F Yrs. 10,1969 Director 223-96-5984 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at MD Prince Georges Clinton 1 ☐ Yes 2 🔀 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 9005 Cheltenham Ave. 20735 238 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 XNo Specify Specify: Completed by 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than College (1-4or 5+) Elementary/Secondary (0-12) Electrician U.S. Government permit. Pages 1 end 2 should be filed v Department of Heelth and Mental Hygie Important: if item 27 is marked other til eny injury or other traumatic event, the sance. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harold Brackett Gertrude Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold Brackett/Father 5607 Eleanor Ct.-Alexandria, VA 22303 20b. Place of Disposition (Name of 20c. Location · City or Town, State 20a. Method of Disposition Bethiehem Babtist 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Church 01/04/06 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Greene Funeral Home, INC. Won E 814 Franklin St.-Alexandria, VA 22314 23a. Part1. Enter the disease; or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a Diabetic Ketoacidosis complicating Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine inding physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Acute and Chronic Pancreatitis 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificete es 2 No 1 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other 4 Nursing Home 5 Residence 6X Other (Specify) SCENE 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by To the Hospitel or At within 24 hours after of To the Funaral Direct completely filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examines: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DECEMBER 31, 2005 wellow M OCME ryo 30. Name and address of person who completed caus of beath (Item 23a) (Type, Print) PENN STREET, BALTIMORE, MARYLAND, 21201 31. Date filed (Month, Day, Year) . Registrar's Signature State

Registrar

JAN 1 8 2006

			1 - For State Registrar	State	of Mary	land / Depa	artmen rtificat			and M		iene ()	05	437	54
	Division		1. Decedent's Name (First, Mid-	dle, Last)							2. Date of Deat Month	th Day	Year	3. Time of	Death
	Physici: /Medic		Doris Butler								Decembe		2005	12:50	AM^{M}
	Examin		4a. Facility Name (If not instituti	on, give street and	number)		4b. City,	Town, or	Location of	of Death		4c. Count	y of Death		
			Future Care	Homewood					more						
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☑	_	yrs. last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	olace (State of	r Foreign UNK
а	Director		215-30-6164	1 W 2 X	70	Yrs.					Jan 2,	1935			
	and *	}	Usual Residence of Decedent 10a. State 10b. Coun	tv	10	c. City, Town or Lo	cation							0d. Inside Cit	ty Limits
	laryli sho	៦	MD	•		Baltimo								1√⊋ Yes	
	the A	Director	10e. Street and Number			Daitillo	10f. Zip	Codo			T 4	Og. Citizen of	What Cour		
	a or						101. 210		1010				Wilat Cou	iti y r	
	eath	Funeral	2700 N. Char1		C Decedent Ever	rin II S 13	Was Daced		1218	gio2 (Sp	acify Vac or No-	USA 14 Ba	ce - Americ	en Indian	
	Iten d	Ę	1 ☐ Never Married 2 ☐ Ma	Arme	d Forces? es 200 No	10.	If Yes, spec	ify Cuba	n, Mexicar	i, Puerto	ecify Yes or No- Rican, etc.)		ck, White,		
33	urs al	b	3 ☐ Widowed 4 ☐ Divorce	if Yes Year	, Give Tor Dates:		1 🗆 Yes	2 <mark>∏</mark> No	Specify:			Speci	^{fy:} b1ac	k	
ğ	2 hot	te d		ent's Education		16a. Dece	dent's Usua	al Occupa	ation		ing unk	16b. Kind of E	Business/In	dustry	
72	hin 7	ple	(Specify only high Elementary/Secondary (0-12	est grade complet	ge (1-4or 5+)	(Give	kind of wo DO NOT us	rk done d se retired	during mos I)	t of work	ing dirk				unk
2	filed within 72 hours atter death with the Maryland Hyglene. other than "natural", or flems 23a or 28e-f show ent, I'ts Madical Exama har must be notified at	Completed	unk	unk	90 (1 40/01)										
פ	0 = 0 5	Bec	17. Father's Name (First, Middle	a, Last)			u	nk	18. Mothe	er's Name	e (First, Middle,	Maiden Suma	me)		unk
<u>la</u>	should be filed within 72 hours atter death with the Marylan nd Mental Hyglene. It marked other than "natural", or Items 23a or 28e-f show unatic event. Ite Medical Exama har quat be notified at	To E													
Maryland 21215-0036	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic enonge.	- 6	19a. Informant's Name/Relation	nship <i>(Type, Print)</i>		19b. Maili	ng Address	(Street a	and Numbe	er or Rur	al Route Number	, City or Town	, State, Zip	Code)	
	and 2 alth n 27 l		Future Care H	omewood		270	0 N.	Char	les_S	itres	t Balti	more. 1	n 2	1218	
Baltimore,	of He	8	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	2 Demoval fo		Ob. Place of Dispo cemetery, crea	sition (Nar	ne of	!	(20c. Location			
<u>Ĕ</u>	Page nent ant: h		' 4 □Donation 5 ☑Other	(Specify) in	state										
alt	pontri pontri y nje		21. Signature of Funeral Service		ella	tor S	2. Name ar	Addres	s of Facilit	ly	655 11	D 1. *		3.	
<u>m</u>	8258	10	mon	1/10	The same	Ba	altim	ore,	MD E	2120	655 W.	Baltin	nore S	street	
П			23a. Part1 Enter the disease, shock or heart failure. Li	or complications that only one cause	nat caused the	death. Do not en	er the mod	e of dyin	g, such as	cardiac	or respiratory arr	est,		Approximate Interval Bety	ween
П	Physician		Immediate Cause (Final disease or condition			le otic	((4)	04 C	دساح	7	2			Onset and D	
	/Medical		resulting in death)	a		onsequence of):									~ `
N	Examiner		Sequentially list conditions.	b. D.	chetis	Mellita	د-						3	ستازيلهن	
	D =	ner	if any, leading to immediate cause. Enter Underlying	Due	o (or as a co	ensequence of):									
	nd rrans	Examiner	that initiated events	c											
, 0	ate be executed hysiclen and the burial-transit	Ě	resulting in death) Last	Due	e to (or as a co	ensequence of):									
8760,	ate be executed obysiclen and the burial-transit	Physician/Medical		d											
9	as as	Med	IF FEMALE:												
Вох	tend tend or us	lan/	23b. Was decedent pregnant in the past 12 months?	1 🗆 L	, outcome of p ive birth 2 □	Fetal death 3	⊒Ectopic pi						ate of delive onth	,	rear .
	the a	Sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		regnant at time Inknown	e of death 5[Other (sp	ecify)							
P.O.	that the death cered by the attending detached for use		Part II. Other significant cond	tions contribution	to death but or	ot regulting in the u	ndorhing c	auso ainu	on in Bort I		23e Did to	bacco use cor	atribute to t	he cause of d	leath?
ds,	ires that signed b	by		_		ot resulting in the c	indonying c	adoo givi	on in raiti			es 2 No	3 ☐ Prot	i.e.	nknown
oro	v requir been si should l	etec	Alskines	Denest	<u> </u>						:	2 2 2 110	0 1 101	70DI) - Q	
Vital Records,	e law hes b	Completed									24a. Was a autops	sy	prior to co	psy findings a mpletion of ca	available ause of
H		Cor									perform 1 ☐ Yes	2 No	death?	2□ No	
/ita	Attending Physicien: Thir death. ector: Atter this certificate by the funeral director, pag	Be	25. Was case referred to medi examiner?					24		of Deat	h (Check only or	18)			
of	Physi this c	5	1 Yes 2 No	-	1 Inpatient	2 ER/Outpatie			4 1919	irsing Ho	me 5 Reside			y)	
n c	ding F	lon	27. Manner of Death Natural 5 ☐ Pen	ding	ate of Injury Month, Day Ye	28b. Time o Injury		8c. Injun Worl		N.L.	28d. Describe h	ow injury occu	rred		
Sic	ttendi death. ctor: A y the fu	cat	2 Accident inver 3 Suicide 6 Cou	d not be	None of Interes	A	M		Yes 2	NO	006 Lanatina /C	tenna and Alice		1 Danta Alima	
Division	in the second	Certification;	4 ☐ Hornicide dete		uilding, etc. (5	- At home, farm, st Specify)	reet, tactor	/, опісе			28f. Location (S. City or Town		iber or mura	II HOUIB NUM	ber,
	To the Hospitel or Attending i within 24 hours etter death. To the Funerel Director: Atter completely filled in by the funer		29a. Certifier 1C Certif	ring Physicians T	a the best of	w knowledge de-	h 0000	at the *	no dota c	nd place	and due to the	augo/s) 554	20000	tated	
	Hos 24 hc Fun stely	edical	(Check only 2 Medic	ring Physician: To al Examiner: On t	he basis of exa manner stated	amination and/or in	vestigation	, in my o	pinion, dea	ith occur	red at the time, d	ate and place	, and due to	tated. o the cause(s))
	o the ithin 2 or the or the omplei	Mec	29b. Signature and title of certi		aimor stateu		29	c. License	e number		2	9d. Date sign	ed (Month.	Day, Year)	
ı	with Con			\					590	56				,	
•			30. Name and address of person	on who completed	cause of death	(ltem 22a) (Turn		عن ر				1/10/00	0		
			30. Name and address of person	Selui-	2 8			7 0	1000	7	Beit	LAC	7:71	7	
	· Sta	ate	31. Date filed (Month, Day, Ye	-	32. Registrar's	Signature			1270		2614	70117	112		
	Regist		IAN 1	8 2006	A Bart an	. M. A	mode	,							

			For State Registrar	State of Maryland	I / Department of Certificate of		ental Hygier	711115	43755
>	Physicia /Medio Examin	al	1. Decedent's Name (First, Middle, Last) Laudin 4a. Facility Name (If not institution, give stre	bet and number)	Couplin		2. Date of Death Month Decomber	Day Year 20 2 4c. County of Deal	3. Time of Death 12:45 pm
	Funeral Director		5. Social Security Number 6. Sex 1 □ N Usual Residence of Decedent	7. Age (In yrs. las	St birthday) If Under 1 Year Months Days	r If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 12-2	9. Bird	thplace (State or Foreign buntry) RginiA
	Maryland B-f show	tor	10a. State 10b. County		Town or Location. Baltimore	2			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	ath with the 23a or 28 ust be not	Funeral Director	1-1-	enson Park		213	10g.	Citizen of What Co	ountry?
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene Importents if Item 27 is marked other then "natural", or Items 23a or 28a-f show applyingly or other traumatic event, I're Mayleal Exertifical Little Capture 2006.	۵	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Spec ban, Mexican, Puerto F o Specity:	cify Yes or No- lican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	filed within 72 h Hygiene. Afher then "natu	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)		16a. Decedent's Usual Occu (Give kind of work don- life. DO NOT use retir	e during most of workin ed)	g	Nind of Business Homen	
Maryland	nould be file I Mental Hy narked oth natic event	To Be	17. Father's Name (First, Middle, Last) SCAR Davis			18. Mother's Name	Grub	65	
	1 and 2 sho Health and em 27 le m		19a. Informant's Name/Relationship (Type Kenneth Davis	(Son)	19b. Mailing Address (Stree 1243 V ace of Disposition (Name of	Patterso.	n PK	Are. B	Ho. Md.
Baltimore	permit. Pages I Department of P Importent: If Its any Injury or ot once.		20a. Method of Disposition 1 □ Burial ≠ ☑ Cremation 3 □ Rer 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune 1/2 = truce List see	agr	metery, crematory or other of APP EN REMARKS	ery 1/4/	ler's Me	Location - City or Ballo 9	nd. Chase
m	8988		23a. Part1. Enter the disease or complica shock, or heart latture. List only one	tions that caused the death.	1639 N Do not enter the mode of dy	BROAD	respiratory arrest,	to. Md.	2/2/3 Approximate Interval Between
	Physician /Medical Examiner	Jer	Immediate Cause (Final/disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of the consequence of t	Enceshelen	n ethy			Onset and Death There Says
68760, <	cate be executed physicien and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):	-			
P.O. Box 6	that the death certificate leed by the attending physidetached for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	If yes, outcome of pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of dear 9 Unknown	death 3 Ectopic pregnan	су		23d. Date of del Month	iivery Day Year
	w requires that the de been signed by the s should be detached	þ	Part II. Other significant conditions contr	buting to death but not result	ting in the underlying cause g	iven in Part I.		co use contribute to 2 □ No 3 □ Pr	o the cause of death?
Division of Vital Records,	The lay ate has page 2	Completed					24a. Was an autopsy performed 1 Yes 2	prior to death?	utopsy findings available completion of cause of
f Vit	nysicier nis certif directo	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{Yes} \) No	pital: 1 ☐Inpatient 2 ☐ E	R/Outpatient 3 DOA O	26. Place of Death ther: 4 ☐ Nursing Hom	(Check only one)	e 6 ⊟Other (Spe	cify)
o uoi	nding PI ath. r: After the funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M 1 [ury at 2 ork? □ Yes 2 □ No	8d. Describe how is	njury occurred	
Divis	el or Atte s after des il Directo d in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specify)		1	8f. Location (Street City or Town, St	tate)	·
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director,	edical C	29a. Certifier 1 Certifying Physic (Check only one)	ian: To the best of my know r: On the basis of examination and manner stated.	rledge, death occurred at the on and/or investigation, in my	time, date and place, as opinion, death occurre	nd due to the cause d at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	MD MD	29c. Licer A U2 23a) (Type, Print)	1176439	5D Dec	Date signed (Mont	h, Day, Year)
1	3		30. Name and a dress of erson who com Nidhi J Desai	pleted cause of death (Item 2	23a) (Type, Print) Myoral Hish	atel, MI	>		
	Sta Registi	733	31. Date filed (Month, Day, Year) JAN 1 8 200	32. Registrar's Signatu	Looks .	,			

DHMH 17 Rev 1/2001

YUN SEN CHEN 05-08762 RKD

) 			For State Registrer	State of Ma	ryland / Depa <i>Cei</i>	artment e rtificate				Reg. No.	11115	4375	56
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) Yun Sen Chen 4a. Facility Name (If not institution, give s 4958 WEBBED FOOT W.			4b. City, To		ation of Dea	2. Date of De Month DECEMB	ER 2	6, 200 County of DO		
	Funeral Director		5. Social Security Number 117 6. Sex		(In yrs. last birthday) 45 Yrs.	If Under 1 Months E	Year If L	Jnder 24 Hrs ours Min		h y, Year)	9. 6	Birthplace (State or I Country) U	Foreign Ink
	72 hours after death with the Maryland natural', or items 23e or 28e-f show Iteal Examirar must be notified at	Funeral Director	10a. State 10b. County MD Howard 10e. Street and Number 4958 Webbed Foot V	2. Was Decedent E	10c. City, Town or Lo Columbia	10f. Zip Co	2	1045	Specify Yes or No		zen of What	10d. Inside City 1 Tyes 2 Country?	
121215-0036	- 30	Completed by	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) unk 17. Father's Name (First, Middle, Last)	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates: ation completed) College (1-4or 5-	16a. Dece	f Yes, specify 1 Yes 2 dent's Usual C kind of work of NOT use	No Sp Occupation done during retired)	pecify: g most of wo		16b. Ki	Black, W Specify:	hite, etc. Isian	unk
Baltimore, Maryland	permit. Pages 1 end 2 should be filed within Department of Heelb and Mental Hygiere. Importent: if item 27 is marked other then eny Injury or other treumatic event, the Model.	To Be	19a. Informant's Name/Relationship (Ty) O . C . M . E . 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R. 4 □ Donation 5 ☑ Other (Specify)	emoval from State		ng Address (S	Street and A	lumber or R	me (First, Middle, Tural Route Number imore, Mi Date	or, City o	r Town, State	o, <i>Zip</i> Code) or Town, State	
Balti	permit. Departm Importe eny Inju	1 12	21. Signal re of Fun, all Service License Ronald S	have ying]	Baltimo	ore. 1	4D - 21	201		1timo:	re Street	
8760,	Physician bhysician bhysician and physician and physician and the privative and the privative and the physician and the	dicai Examiner	23a. Part1. Enter the disease, or complications shock, or heart failure. List only on timediate Cause (Final disease or condition resulting in death) Sautentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	e. Higher State a consequence of): a consequence of): a consequence of):							Approximate Interval Betwee Onset and De	en iath
P.O. Box 6	iaw requires that the death certificate be execu ss been signed by the eltending physicien end 2 should be deteched for use as the burial-tran	Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic preg Other (spec				2	23d. Date of o	delivery Day Ye	nar
Records, P.	requires that een signed b nould be dete	ρ	Part II. Other significant conditions con	tributing to death bu	t not resulting in the u	nderlying cau	se given în	Part I.	23e. Did to		V	to the cause of dea	
ital Rec	The he he	Se Completed	25. Was case referred to medical				26.	Place of De		sy med? 2□No	prior t	autopsy findings av o comptetion of cau ? es 2 □ No	allable use of
Division of Vital	ng Phy Iter this neral d	Certification; To B	examiner? 1 X Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injur (Month, Day 12/26/0 28e. Place of Inju	ry - At home, farm, str	AM 28c	Work? 1 ☐ Yes		28f Location /6	ow injur	Stall 9	OPECITY) SCENE Cut Rural Route Numbe	θτ,
Ö	To the Hospital or Attendir within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Medical Cert	29a. Certifier 1 ☐ Certifying Phys	icien: To the best of	house Ro f my knowledge, deatl examination and/or in	n occurred at vestigation, in	the time, da	ate and place	City or Tow Way e, and due to the ourred at the time,	Col	and manner	webbed for a stated. ue to the cause(s)	pot
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	end manner state			.C.M.		1		-	7, 2005	
	Sta	te	30. Name and address of person who con CUALOL H AZU 31. Date filed (Month, Day, Year)	tume	r's Signature	111 F	PENN S	STREET	BALTIMO	RE,M	ARYLAN	D 21201	
	Registr		JAN 2 0 2006	A Comment	B Agoss	Bank .							

			1 - For State Registrar	State of Marylar		artment of F tificate of			giene Reg. No.	005	43757
	Physici	an	Decedent's Name (First, Middle, Later		,			2. Date of De	ath Day	Year	3. Time of Death
13	/Media		ANNA	DELI				12	27	05	9.37 A.M.
	Examir	er	4a. Facility Name (If not institution, give HAMMONDS LANE C	TO GISHAMIN	10N DSLA		r Location of D	8ath 1225	4c. 0	County of Dea	th
	- N		5. Social Security Number 6. S	DECEKTYN PK		5 HAMMO If Under 1 Year	NDSLAN	& CTR.	h	0 D:-	Aboles (Correspondented
	Funeral Director		1	□M 2⊞F	Yrs.	Months Days		Ain. (Month, Da	y, Year)	C	thplace (State or Foreign ountry)
	er .		217-26-1265 Usual Residence of Decedent	- X 82				Nov 2,	1923	Ca	nada
	yland 10W		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
	Man	to	MD	В	rook1y	n Park					1 ☐ Yes 2 ☐ No
	r 28s	Director	10e. Street and Number		roomry.	10f. Zip Code			10g. Citiz	en of What C	ountry? unk
	h witi	o ie	613 Hammonds La	ne		212	225				
	72 hours after death with the Maryland neturel', or Iteme 23a or 28a-f ehow Jost Examiner must be neitlied at	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13.	Was Decedent of I	lispanic Origin	? (Specify Yes or No uerto Rican, etc.)	- 1	4. Race - Ame	
9	or Ite	T.	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 No				ueno Rican, etc.)		Black, Whi	
8	rell,	l by	3 ₩idowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		,	Specify: V	<i>v</i> hite
5	72 h	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)		ient's Usual Occup		workina	16b. Kin	d of Business	/Industry
21	within ene. then	ф	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)				
7	Hygier Hygier other ti	S	12	0		laborer				ttle f	actory
밀	be fill Hold off	Be	17. Father's Name (First, Middle, Last,				18. Mother's	Name (First, Middle,	Maiden S	Sumame)	unk
yla	2 should be and Mentel Is marked aumatic ev	ပ္	Mike Fra								
Maryland 21215-0036	2 sh and Is m	ļ	19a. Informant's Name/Relationship (Will	19b. Mailir	ng Address (Street	and Number o	r Rural Route Numbe	er, City or	Town, State,	Zip Code)R2M1N1
	lealth m 27 her tr		Josephine Cyncare				enue We	st Winnip			
Baltimore,	_ T 5 5		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	Place of Dispo cemetery, crer	sition (Name of natory or other pla	сө)	Date	20c. Loc	ation - City or	Town, State
Ē	Pag ment ant: ury c		4 □Donation 5 X Other (Specif	in state							
a	permit. Pages Department of Important: If i eny injury or one		21. Signature of Funeral S. rvice Licer Ronal d S.	Wade Virecto	r st	Name and Addre	ss of Facility	ard 655 W.	Bal	timore	Street
Ш	80 E = 0		- winny	11	Ba	altimore,	MD 21	L201			
			23a. Part i Enter the disease, or com shock, or heart failure. List only	plications that caused the dea one cause on each line.	th. Do not ent	er the mode of dy	ng, such as car	diac or respiratory ar	rest,		Approximate Interval Between
8	Physician		Immediate Cause (Final disease or condition	Rustured	1 th	ωναςί	\mathcal{A} _	neury			Onset and Death
	/Medical		resulting in death)	Due to (or as a consec	quence of):		•	11.00.00			
	Examiner		Sequentially list conditions,	b							
	p =	ner	rany, leading to infinediate cause. Enter Underlying	Due to (or as a consec	quence of).						
	death certificate be executed e attending physicien and id for use as the burial-transit	Examiner	that initiated events	c							
Ő,	e exe		resulting in death) Last	Due to (or as a consec	quence of):						1
8760,	icate be ex physicien s the buria	ica		_ d		····					
9	ntific ing pl	Physician/Medical	IF FEMALE:								
Вох	eath certific attending p I for use as	an/	23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet:		Ectopic pregnanc	v		2	3d. Date of de	
	the at	sici	in the past 12 months?	4☐ Pregnant at time of of the second of the	death 5□	Other (specify)				Month	Day Year
P.0	± ≻ ≥	Phy	9 ☐ Unknown								
Ś	requires thet een signed b nould be deta	þ	Part II. Other significant conditions	contributing to death but not re-	sulting in the u	nderlying cause gr	ven in Part I.	23e. Did to	obacco us	e contribute t	o the cause of death?
of Vital Record	w requir been si should	P						_ 101	res 2□]No 3∏P	robably 4 Cunknown
သူ	as b	Completed						24a. Was		24b. Were a	utopsy findings available
č	The age	E							med?	death?	comptetion of cause of s 2 □ No
ita	sician: certifical rector, p	0	25. Was case referred to medical				26. Place of	Death Check only o			, 10,110
>	\$ w = 0	OB	examiner? 1 Tes 2 No	Hospitat:	ER/Outpatier	nt 3 DOA Ott		ng Home 5 ☐ Resid		□Other (Spe	ecify)
0		T:U	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo		28d. Describe			
ō	Attending I r death. ector: After by the funer	atio	1 Natural 5 ☐ Pending 2 Accident investigatio		mjury		Yes 2 □ No				
Division	or Attendate death after death Director;	ertification:	3 Suicide 6 Could not b		ome, farm, str	eet, factory, office		28f. Location (S City or Tox	Street and	Number or R	ural Route Number.
\Box	s afte of Dire	Cert		building, etc. (Speci	·y)			Ony or row	vii, State)		
	Hospitel or Atti 24 hours after de Funerel Directo stely filled in by ti		29a. Certifier Certifying Pl	ysician: To the best of my kn	owledge, deatl	n occurred at the ti	me, date and p	lace, and due to the	cause(s) a	and manner a	s stated.
	he Hos in 24 hc he Fun pletely	ledical	(Check only 2 Medical Example)	niner: On the basis of examinand manner stated.	ation and/or in	vestigation, in my	opinion, death o	occurred at the time,	date and	place, and du	e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and tyle of certifier			29c. Licens					th, Day, Year)
			P.V.	· w	0		0239	162		iliplo	6
-			30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,	Print)		62 6len B		. , , , , ,	
			Jude Muneses	MD 784	S DA	Kwood	Road	Glen B	wrwi	e. m	1 2005 A
1	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	S. S		- 1711-F	-1.411		
	Regist	rar	JAN 2-0-200	D Allowed S	S Well and						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 24, Nina Jane Guthrie December 2005 10:55 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Elkridge 6391 Rowanberry Drive #401 Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Apr 9, 192 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 1 F 1921 Director 84 216-12-6597 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or iteme 23s or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2√☐ No Director Elkridge Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6391 Rowanberry Drive #401 21075 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ If Yes, Give Year or Dates: Specify: white 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ie marked other then Elementary/Secondary (0-12) College (1-4or 5+) 11 homemaker own home or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Leroy Gardner Lucy Virginia Muir permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 ie m eny injury or other re-19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Guthrie/daughter 5764 Stevens Forest Road #426 Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street muri 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MOINC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-tran the attending physicien and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy detached for in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 🗌 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peed 24a. Was an autopsy performed? 1 ☐ Yes 2 € No 24b. Were autopsy findings available prior to completion of cause of death? this certificate has 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ine Hospitel or And in 24 hours after death. In a Director: After this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide within 24 hours a 1x. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D31575 JANUARY 3, 2066 30. Name and address of person who completed ca of death (Item 30a) (Type, Print) 201 ElKRIDE MO 21075 ARIC 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 8 Registrar

DHMH 17 Rev 1/2001

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician			State of Maryland / 1- State Registrar Amend ITem #5 Per FH G851	Department of Health and I		iene 005	43759
# As Pacifity Name (if frost productions, per larger and numbers) As Pacifity Name (if frost productions) and productions) As Pacifity Name (if frost p	Physic	ian	Decedent's Name (First, Middle, Last)		2. Date of Death Month	n Day Year	
Johns Hopbins Hospital Second Control C							2.04p W
Provided Provided	Exam	iner		, ,		4c. County of Death	
100. Sines and Number 100.		_	5. Social Security Number 6. Sex 7. Age (In yrs. last to 12-29-6063	birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	rear) Cou	ntry)
Specify cold princed grants and completed Specify State Specify Sp	p .			um out continu			104 1-14-01-11
Specify only impless grade completed) College (1-4 or 5+) STUDENT Telephonic Manage (First, Middle, Market) Telephonic Market (First, Middle, Market) Telephonic Market (First, Middle, Market) Telephonic Market (First, Middle, Market) Telephonic Market (First, Middle, Market) Telephonic Market (First, Middle, Market) Telephonic Market (First, Middle, Market) Telephonic Market (First, Middle, Market) Telephonic Market (First, Middle, Market) Telephonic Market (First, Middle, Market) Telephonic Market (First, Middle, Market) Telephonic Market (First, Middle, Market) Telephonic Market (First, Middle, Market) Telephonic Market (First, Middle, Market) Telephonic Market (First, Middle, Market) Telephonic Market (First, Middle, Ma	anyla	5					•
Specify cold princed grants and completed Specify State Specify Sp	he M	ecto					
Specify cold princed grants and completed Specify State Specify Sp	with t	급			10	-	
Specify cold princed grants and completed Specify State Specify Sp	eath	era			posity Von or No		
Specify cold princed grants and completed Specify State Specify Sp	rs after d		1 □X Never Married 2 □ Married		Rican, etc.)	Black, White,	etc.
Roxanne Adams Mother 1730. N. Wolfe Street Baltimore, Md 21213 200. Marea and Adams Mother 1730. N. Wolfe Street Baltimore, Md 21213 201. Merical Disposition 113Musa 2 Clownship 113M	2 hou	ed		ia. Decedent's Usual Occupation		16b. Kind of Business/Ir	dustry
Roxanne Adams Mother 1730. N. Wolfe Street Baltimore, Md 21213 200. Marea and Adams Mother 1730. N. Wolfe Street Baltimore, Md 21213 201. Merical Disposition 113Musa 2 Clownship 113M	2 2 a a a	plet	(Specify only highest grade completed)	(Give kind of work done during most of wor	king		,
Roxanne Adams Mother 1730. N. Wolfe Street Baltimore, Md 21213 200. Meriod of Disposition 118 Junior 2 College of Disposition 118 Junior	y with	E		STUDENT		Educa	ation
Roxanne Adams Mother 1730. N. Wolfe Street Baltimore, Md 21213 200. Marea and Adams Mother 1730. N. Wolfe Street Baltimore, Md 21213 201. Merical Disposition 113Musa 2 Clownship 113M	Hyg othe			18. Mother's Nan	ne (First, Middle, M	faiden Surname)	
Roxanne Adams Mother 1730. N. Wolfe Street Baltimore, Md 21213 200. Marea and Adams Mother 1730. N. Wolfe Street Baltimore, Md 21213 201. Merical Disposition 113Musa 2 Clownship 113M	Id by Menta	0	Micheal Harris		Roxa	nne Adams	
20. Memori of Disposition 1.3 Bruta 2. Common State 2. Signatury of Funyfins Skylva Locenses 2. Signatury of Funyfins Skylva Locenses 2. Signatury of Funyfins Skylva Locenses 2. Signatury of Funyfins Skylva Locenses 2. Signatury of Funyfins Skylva Locenses 2. Signatury of Funyfins Skylva Locenses 2. Signatury of Funyfins Skylva Locenses 2. Signatury of Funyfins Skylva Locenses 2. Signatury of Funyfins Skylva Locenses 2. Signatury of Funyfins Skylva Locenses 2. Signatury of Funyfins Skylva Locenses 2. Signatury of Funyfins Skylva Locenses 2. Signatury of Funyfins Skylva Locenses 2. Signatury of Funyfins Skylva Locenses 2. Signatury of Funyfins Skylva Locenses 2. Signatury of Funyfins Skylva Locenses 2. Signatury of Funyfins Skylva Locenses 2. Signatury of Locens	short and h		19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address (Street and Number or Ru	ral Route Number,	City or Town, State, Zip	Code)
1/2 Survival 2 Commence C	alth a		Roxanne Adams Mother	1730. N. Wolfe Street Baltin	more, Md 212	213	
Approximate the treatment of course of programmy and the sease of control of course of course of the	othe other		come	of Disposition (Name of tery, crematory or other place)	Date 2	20c. Location - City or T	own, State
Approximate the treatment of course of programmy and the sease of control of course of course of the	Page Page Nent c	1.	1 Buriai 2 Cremation 3 Hemoval from State		01/05/06	BALTIMO	RE, Md
Approximate the treatment of course of programmy and the sease of control of course of course of the	mit.	á	21. Signatury of Funeral Service Licensee		_		
Approximate the treatment of course of programmy and the sease of control of course of course of the			groff mythelle				2
FFEMALE: 23b. Was deceded tregnant in the past 12 months? 1 Ves 2 No 2 Other (specify) 2 Other (specify)	/Medica Examined clan and ourial-transit	Examiner	Sequentially list conditions, if any, Learny to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	e of): DE OF);	VM[PCILT]	11 (100)	
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28b. Time of Injury at Work? 28c. Place of Death (Check only one) 27. Manner of Death 28d. Describe how injury occurred 28d. Describe how i		0	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death				
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 2 Noticide 4	dS, ruires that isigned to id be detailed	þ	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.		10	
26. Place of Death (Check only one) 27. Manner of Death Check only one Liver of Death Liver of Death		Complete			autops	y prior to co ned? death?	mpletion of cause of
Starpation Sta	VIII: ician ertific ector,	Be	examiner?		th (Check only on	9)	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Signature and title of certifier 29b. Signature and didrect of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		I	1 Storpatient 2 EH/	Outpatient 3 DOA 4 Nursing H			(y)
29a. Certifier (Check only one) 29a. Signature and title of certifier 29b. Signature and didress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ing F ing F After uner	lo o	1 Natural 5 Pending (M pth, Day Year)	Injury Work?	28d. Describe ho		11
29a. Certifier (Check only one) 29a. Signature and title of certifier 29b. Signature and didress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	SIC Itend Seath Seath tor: ,	cat	2 Suiside 6 Could not be	7	JV3_	- 1 / 1	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	or Al	Ħ	determined 286. Place of Injury - At nome.	farm, street, factory, office	City or Town	, State)	LCVC
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AANY G-LINUS 111 PENNST BALTIMONE WANY LINES 212 US	pltal ours a seral (20s Cartifier 10 Cartifying Physician 7 11 1 1	In death assured	OLW 6		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AANY G-LINUS 111 PENNST BALTIMONE WANY LINES 212 US	Hos 24 ho Fune tely f	lica	(Check only 2 Medical Examiner: On the basis of examination	ige, death occurred at the time, date and place and/or investigation, in my opinion, death occu	, and due to the ca rred at the time, da	luse(s) and manner as s ite and place, and due t	stated. o the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AANY G-LINUS 111 PENNST BALTIMONE WANY LINES 212 US	thin 2 the mplel		and manner stated.				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AANY G-MINUS 111 PENN ST ISALTIMONE MANY LIMB 212 US State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	7 V.		255. Signature and the district				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AANY G-KINUS III PENNST ISALTIMORIE, WANY LAWD Z 12 U S State 31. Date filed (Month, Day, Year) 32. Registrar's Signature				UCME		DECENSON 2	-9, Zeos
State 31. Date filed (Month, Day, Year) 32 Negistrar's Signature	2		30. Name and address of person who completed cause of death (Item 23)	a) (Type, Print) PENNST RATINGE	28 1A1	VI 2010 21	201
	S	tate	31. Date filed (Month, Day, Year) 32 Registrar's Signature	13/10/11/01	- Jan He	1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 2 State of Manyland 1 Department of Health and Mental Hygiene For A State Registrar Certificate of Death Reg. No eath 1 Decedent's Name (First, Middle, Last) 2 Date of I **Physician** /Medical (If not institution, give street and 4b City Town or Location of Death 4c. County of Death Examiner If Under 24 Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 215-07-9520 1 □ M /at Dec Director 18 1916 PA Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b County 10a. State 10d. Inside City Limits or 28a-f show other treumatic event, the Medical Executor must be notified at Md Montgomery Sandy Spring 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 17310 Quaker Lane 20860 238 USA Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death a nent of Health and Mental Hygiene. ant: If Item 27 Ie marked other then "naturel", or Iteme 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 √ No 3 ☐Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) domestic homemaker 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Barrett 2 19a. formant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Barrie Lau (Son) 12518 Marlow Road Fulton, MD 20759 20a. Method of Disposition
1 △ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 6 Depertment of Important: If eny Injury or one Lake View Memorial Park 10/24/05 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesvile, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on caused the death. Do not enter the meach line. Perforated node of dying, such as cardiac or respiratory arrest,

Stomach ulcer with complications Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner burial-transit The taw requires that the death certificate be executed resulting in death) Last (or as a consequence of) physician s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical CERTIFICATION APPROVED BY MEDICAL EXAMINER 98 IF FEMALE 980 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant atten for u 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Status post surgical repair of perforated ulcer, 9 Probably 1 ☐ Yes 2 CIN 4 DUnknown Completed Hypertension, Crohn's Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 certificate 1 ☐ Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: with in 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p. Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) X Yes Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Xiatural 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Combring Physicien: To the best of my knowledge, death occurred at the time, date and albeit at the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one)

State Registrar 31. Date filed (Month, Day, Year) 8 2006

29b. Signature and title of certifier



30. Name and address of person or completed cause of death (Item 23a) (Type, Print)

439 927

29c. License number

29d. Date signed (Month, Day, Year)

			1- For Amend Item 25 State of Manyland / Department of Health and I	Mental Hy	•	43761
	Physici /Medio Examin	al	4a. Facility Name (If not institution, give street and number) Aby City, Town, or Location of Death Aby City, Town, or Location of Death	2. Date of De. Month	Day Year County of Death	3. Time of Death
	Funeral Director		5. Social Security Number 6. Sex 17. Age (In yrs. last birthday) If Under 1 Year Months Days Hours Min. 1X M 2 F 46 Yrs.	8. Date of Bird (Month, Da	y, Year) Couini	ace (State or Foreign try) M.D.
	ith the Marylar or 28e-f show	ector	MD NA Baltimore			0d. Inside City Limits 1 XYes 2 No
036	urs after death w al', or Items 23a Examiner aust L	by Funeral Director	106. Street and Number 1038 North Ellamont Street 21216 11. Marital Status 1	pecify Yes or No Rican, etc.)		• an Indian,
21215-0036	ithin 72 ho ne. nan "natur	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Decupation (Give kind of work done during most of work life. DO NOT use retired)	king	16b. Kind of Business/Ind	
and 21	id be filed w ental Hygier ked other ti c event, IL	To Be Cor		ne (First, Middle,	Various J	obs
ore, Maryland	permit. Pages I and 2 should be filed within 72 ho Deparlment of Health and Mental Hygiene. Importent: if item 27 is marked other than "natur eny injury or other treumatic event, It a Madical once.	Ĕ	19a. Informant's Name/Relationship (Type, Print) Margaret Miles-Mother 1038 North Ellamon 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State	t Stre	er, City or Town, State, Zip	Md 21216
Baltimore,	permit. Pa Departmen Importent: eny injury once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave		Arbutus, Mo	21215
8760,	The law requires that the death certificate be executed with the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	or respiratory ar	(MOS)	Approximate Interval Between Onest and Death A A A A A A A A A A A A A A A A A A A
P.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4	ON APPROVED BY	23d. Date of deliver Month	y Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions countibuting to death out not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contribute to the	e cause of death?
Vital Records,		Completed	Severe Malnutrition Cardiomyopathy	24a. Was a autop perfor	sy prior to com med? death?	sy findings available pletion of cause of
Division of Vit	ding Ph h. After th funeral	Certification: To Be	27. Manner of Death 1	ome 5 ☐ Resid 28d. Describe h	ence 6 Other (Specify) ow injury occurred itreet and Number or Rural	
્ર ≧	afte Dire		building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	City or Tow	m, State) cause(s) and manner as sta	ited.
	To tha Hospite within 24 hours To the Funerel completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated. 29b. Signature and title of periods 29c. License number	red at the time, c	date and place, and due to be 29d. Date signed (Month, D	the cause(s)
	Sta Registr	_	30. Name and addies of person who completed cause of death (Item 23a) (Type, Rrint) H. Nen Ceynolds Ben Second Horpital, 200 31. Date filed (Month, Day, Pazi) 6 32. Registrary Signature	bwat	Ballimons	Shoot

State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death Reg. No. 2 Date of Death lent's Name (First, Middle, Last) 3. Time of Death 622 Physician Sel /Medical 4c. County of Death Facility Name (If not institution, give street and number) Center 4b., City, Town, or Location of Death Examiner aPlata harks Count Nursing and Kehab If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 257 F Days Hours Yrs. 495-40-9155 83 Mar 2, Director 1922 Austraila Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show The Medical Exeminer must be notified at 1 ☐ Yes 2√ No Charles LaPlata Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10200 LaPlata Road 20646 death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: white þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry 15. Decedent's Education unk (Specify only highest grade completed) other then Elementary/Secondary (0-12) College (1-4or 5+) unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk Be . Pages 1 and 2 should be fi tment of Health and Mental H tant: If item 27 is marked otl ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles County Nursing Center 10200 LaPlata Road LaPlata, MD 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 □ Donation 5 ☒ Other (Specify) in state 21. Signature of Funeral Service Licensee Wa 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

23a. Part1. Inter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) signed by the attending physician and dibe detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Examl that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 THO 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2 No 1 Yes After this certification 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Vursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Aatural 5 Pending To the Funeral Director: Aft To the Funeral Director: Aft 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospitel 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) eq. 29b. Signature and title of configr 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 dd line antre ne vood 31. Date filed (Month, Da Day, Year) 32 Registrar's Signature State 18 2006 Registrar

BABY BOY PATRIA 05-08191 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Unpend item# 23a,77,28a-f, penYE, (851,1/21/05 II)
State of Maryland / Department of Health and Mental Hygiene
Amend item 20b per in 8852 certificate of Death
Reg. No. RJ 43763 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 4, 2005 **Physician** 9:38 р. м Baby Boy Patria /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Arnold Anne Arundel 345 Buena Vista Avenue 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Yrs. unk Director none Usual Residence of Decedent with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits - Phow r then "naturel", or Iteme 23a or 28a-f eho the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? unk 345 Buena Vista Avenue 21012 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Slatus 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) none none none none permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Importent: If Item 27 is marked oth eny liury or other traumatic event 200e. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OCME 111 Penn Street Baltimore, MD 21201 20c. Location - City or Town, Slate 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Metro Crematory Inc 1-14-06 Baltimore, Md. 4 □Donation 5 □Other (Specify) in state 21. Signature Funeral Service Licensee Ronald S. Wade 22. Name and Address of Facility Lassahn Funeral Home 21236
State Anatomy Board 555 W. Baltimore Street Baltimore, MD 21201 7401 Belair Rd. will Balto. Md23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Asphyxia and Exposure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit thet the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Day 4□Pregnant al lime of death 5 Other (specify) P.O. 9 Unknown 9 Unknown is been signed by the should be detach. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 24 Yes 2 □ No 24a. Was an autopsy performed? 1X Yes 2 🗆 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) At SCENE 1X Yes 2 No -endir, er death. -tor: After th. e funeral de 28a. Date of Injury Link (Month, Day Year) | 28b. Time of Unik 28d. Describe how injury occurred Baby delivered 28c. Injury al Work? 27. Manner of Death Certification; 1 Natural 5 Pending in toilet, placed in plastic trash bag 1 Yes 2 No 2 Accident investigation disposed of in trash can outdoors Location (Street and Number or Rural Route Number, City or Town, State) 345 Buena Vista Road 6 Could not be determined 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide Home Arnold, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica Medical Examiner. On the basis of examination at J/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME December 5, 2005 ed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year, JAN

30. Name and address of person who compl

ABIUCCATO

32. Registrar's Signature

9

AZ

	_1	For State Registrar	State of N	nai ytai lü		rtificate					Reg. No	000		010	Eu ja
siciar		1. Decedent's Name (First, Middle, L	ast)						,	2. Date of De Month	Da		ear	3. Time of De	
edica	ıl .									Deen			005	01007	IVI
mine	r '	4a. Facility Name (If not institution, go	10	.)	G.	4b. City,	I own, or	Location o	Juliu		40	. County of		7 merre	
al		5. Social Security Number 6.	Sex 7.	Age (In yrs. Ia.	st birthday)	If Under	1 Year	If Under		8. Date of Bir	th			ce (State or F	oreign
			1 <u>M</u> M 2□F	42	Yrs.	Months	Days	Hours		B. Date of Bii (Month, Da Sept 2				y) Land	
		Usual Residence of Decedent								bept z					
١.	- 1	10a. State 10b. County			Town or Lo								10	d. Inside City I	
	by Funeral Director	MD Baltimo	ore		Parkv	ille								1 Tyes 2	7 140
1	- Le	10e. Street and Number				10f. Zip	Code				10g. Ci	tizen of Wha	at Count	у?	
100	ra La	1801 WEntworth R	- 1		1			1234				USA 14. Race -	Amorian	n Indian	
1	nue	11. Marital Status	12. Was Deceder	s?	13.	Was Deced	offy Cuba	n, Mexicar	igin? (Spec 1, Puerto R	rify Yes or No lican, etc.)	,-		White, e		
	2	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 € If Yes, Give 4 Year or Date:	Λ		1 ☐ Yes	2 No	Specify:				Specify:	whit	ce	
4	ed	15. Decedent's		1	16a. Dece	dent's Usua	al Occupa	ation		unk	16b. K	(ind of Busin			unk
4011	plet	(Specify only highest g	rade completed) College (1-4d	\ F.\\	(Give life.	kind of wor DO NOT us	rk done d se retired	during mos l)	t of workin	g diffe					GIII
-	Completed	Elementary/Secondary (0-12)	0	n 5+)											
9	Be C	17. Father's Name (First, Middle, La.	st)			_		18. Mothe	er's Name	(First, Middle	, Maidei	n Sumame)			unk
2	2	John F. Ruth	Sr												
ľ		19a. Informant's Name/Relationship	(Туре, Print)		19b. Maili	ng Address	(Street a	and Numb	er or Rural	Route Numb	er, City	or Town, St	ate, Zip (Code)	
		Richard Ruth/bro	other					e Roa	_	ltimor	e, M	D 21	224		
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	□Domeyal from Sta	CO	ace of Dispo metery, cre	osition (Name matory or o	ne of ther plac	e)	Da	ate	20c. L	ocation - Ci	ity or Tov	n, State	
		'4 □ Donation 5 ☑ Other (Spec	in stat	e 7											
		21. Signature of Funeral Service Lice Ronald S.		restor		2. Name an State Balti	Ana	tomy	Board 2120		И. В	altim	ore	Street	
ı		23a. Part1. Inter the disease, or shock, heart failure. List on	mplications that caus	sed the death.						-	rrest,			Approximate Interval Betwe	en
ı		Immediate Cau Final	ly one cause on each	_	اعمدا	1110	- 1	7.50					1	Onset and De	ath
ı		disease or condition resulting in death)	a. Due to (or	as a conseque		-100	i a	1800	132						
	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	ence of):										
•	Examiner	that initiated events	c.												
		resulting in death) Last	Due to (or	as a consequ	ence of):										
	dical		d									_	-		
	Med	IF FEMALE:					150.0				- 1	-		77	
-	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal	death 3	Ectopic p		1				23d. Date of Month		y Day Ye	ar
	Physiclan/Med	1 Yes 2 No	4∏Pregnan 9∏Unknowr	t at time of de n	ath 5	Other (sp	oecify)							,	
	Phy.	Part II. Other significant conditions	a contributing to doct	h hut not room	Iting in the I	undorhing o	auca ant	on in Dart	ı	23e Did	tohacco	use contrib	ute to the	a cause of dea	ith?
١.	by	Part II. Other significant conditions	contributing to deat	n but not resu	itang in the t	andenying c	ause giv	OIT III T DATE	1,		Yes 2		Proba	1 -	
	eted						-			-					
•	nple									24a. Wa		pric	ere autop or to com ath?	sy findings av ipletion of cau	se of
-	Comple									1 ☐ Yes	2 N	o 1E	Yes :	SIMNO	
	Be	25. Was case referred to medical examiner?	Monitoli				Oth	on 11	3	(Check only					
Ш	P	1 Yes 2 No	Hospital: 1 _ Inp		ER/Outpatie	_		3/	-	ne 5 Res)	
l.	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Month,	Day Year)	28b. Time o Injury	M M	28c. Injur Wor	yax k? Yes 2.⊑		8d. Describe	now mji	ary occurred			
	cat	2 Accident investigat 3 Suicide 6 Could no	ha l	Informa At hou	mo form o	-1		163 2		9f Location	(Street a	nd Number	or Bural	Route Numbe	ar.
1	H	4 Homicide determine		, etc. (Specify	me, tarm, s	reet, ractor	y, onice		-	City or To	wn, Sta	te)	0, 710,27	7100101101100	1
	edical Certification:	29a. Certifier Gertifying	Physician: To the be	not of my know	ulodgo dos	th convered	Lat the tie	ne date a	nd place a	nd due to the	rausel	s) and mans	ner as sta	hete	
l	lica	(Check only one)	aminer: On the basi	s of examinati	ion and/or i	nvestigation	n, in my o	pinion, de	ath occurre	d at the time	, date ar	nd place, an	d due to	the cause(s)	
	Mec	29b. Signature and title of certifier	1	Statou.		29	c. Licens	e number			29d. D	ate signed ((Month, D	Day, Year)	
Ш									71/2-	>	1		1	2,00	00
l			. /	1				- 17 1	ILL /	\	led in	100 00	- 10	C (C	-
		/hand		1	00 1 7	Divi	100	003	170	7	3 - 000	.a.a.	7		
		30. Name and address of person wi	no completed cause	of death (Item	23a) (Type	Print)	Want	SP	of o	Builde	,	# 20		(1	

	,	1 - For State Registrar		aryland / Do	Certificate			leg. No.	105	4376
		1. Decedent's Name (First, Middle,	. Last)				2. Date of Dea		Voor	3. Time of Death
Physicia		Robert Samy					Novembe	r_{27}^{pay}	2005	12:35 P'
/Medic Examin		4a. Fecility Name (If not institution,	give street and number)		4b. City, To	wn, or Location of Death	7	4c. Cou	nty of Death	
		308 East Lafavet	te Street		Balti	more				
Funeral		5. Social Security Number unk	6. Sex 7. Ag	e (In yrs. last birth	day) If Under 1 h		8. Date of Birt (Month, Da)	Year)	9. Birthp	lace (State or Forei
Director			1₩ 2□F	35 ^{YI}	rs.		Dec 12,	1969		dir
put &		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town	or Location				1	0d. Inside City Limi
ehow	ក		لبعد	Edgew						1 □ Yes 2√2 i
ING Z 1 Z 1 3-UU30 be filed within 72 hours atter death with the Manyland tal Hyglene d other then "natural", or items 23e or 28e-f ehow event, the Medical Examinar must be motified at	Funeral Director	MD Harfe	ora	Lugew	10f. Zip Co	ode		10a Citizen	of What Cour	
e or	늄				101. 2.0			rog. Onizon	or rinar oour	шу.
er death w items 23e	eral	1823 Grempler 11. Marital Status ur	Way 1k 12. Was Decedent	Ever in U.S.	13. Was Deceden	21040 It of Hispanic Origin? (S	pecify Yes or No-		USA Race - Americ	an Indian.
ter d	5	1 Never Married 2 Marrie	Armed Forces?	unk	If Yes, specify	Cuban, Mexican, Puert	o Rican, etc.)		Black, White,	etc.
Maryland Z1Z13-UU30 ud 2 should be filed within 72 hours at the and Manial Hygiens. 27 is marked other then "natural; or traumatic event, the Modical Expiri	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 200	No Specify:		Spe	city: b1	Lack
atura est	Completed	15. Decedent		16a. C	ecedent's Usual C	Occupation	unk	16b. Kind o	Business/Inc	dustry un
Media 7	ble	(Specify only highes Elementary/Secondary (0-12)	College (1-4or		life. DO NOT use	done during most of wor retired)	rking			
d wit	Š	unk	unk	,						
e file al Hy loth	Be (17. Father's Name (First, Middle, L	_ast)		unk	t 18. Mother's Nam	me (First, Middle,	Maiden Sun	name)	un
uld b Aenta rrked	To									
2 should be 1 and Mental I ie marked of		19a. Informant's Name/Relationsh	nip (Type, Print)	19b. I	Mailing Address (S	Street and Number or Ru	ural Route Numbe	r, City or To	wn, State, Zip	Code)
		O.C.M.E.				Street Balt		ID 21	201	
Darkillore, Dermit. Pages 1 ar Department of Hee mportant: if item: nny injury or other	1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	2 Domoval from State	20b. Place of Cometery,	Disposition (Name , crematory or othe	of er place)	Date	20c. Location	on - City or To	wn, State
Pages nnt: if ite		4 □ Donation 5 ☑ Other (Sc	pecify) in state			ļ				
permit. Pages 'Department of himportant: if ite eny injury or ot once.		21. Signature of Funeral Service L	Licensee ///	1.1.	22. Name and	Address of Facility	1 (55 **			
permi Depa impo eny ir	5 8	Ronald S	. Wade Mix	ector	Baltimor	natomy Board e, MD 2120	d 655 W.	Balti	more S	treet
		23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that caused	the death. Do no	ot enter the mode of	of dying, such as cardiac	c or respiratory ar	rest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Heroi	1	Cocains	intoxic	41.00		***	Onset and Death
/Medical		resulting in death)	_ a	a consequence of		700, 000	100			
Examiner										
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	ان میسوسودانی با)-					
cuted	Examiner	that initiated events	c							
exe an ar rial-t		resulting in death) Last	Due to (or as	a consequence of	·);					
icate be executed physician and s the burial-transit	dical		d.						_	
rtificate be ex ng physician a as the burial.	Jed	IE EEMAL C.						1		
leath certific attending p	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetel death	3 ☐Ectopic preg	nancv		1	Date of delive	
thet the death	SICE	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a 9☐Unknown		5 Other (spec				Month	Day Year
et the	Å.	9 Unknown								
ds, T.C.	by	Part II. Other significant condition	ns contributing to death b	out not resulting in	the underlying cau	se given in Part I.				ne cause of death?
w requir been s	ted						101	′es 2 □ No	o 3 🗍 Prob	abiy 4 Unkno
law range as be	ple						24a. Was	SV	b. Were auto	psy findings availal
The la	E						, perfo	rmed? 2 ☐ No	death?	
vician: The l certificate ha	Bec	25. Was case referred to medical	110,000	Order Co.		26. Place of Dea	ath (Check only o			
Physici Physici this ce	ToE	examiner? 1 ∑ x es 2 □ No	Hospital: 1 Inpatio	ent 2 ER/Outp	patient 3 DOA	Other: 4 Nursing H	dome 5 ☐ Resid	lence	Other (Specif	y)Scene
Fer th		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Inju	ury 28b. Ti	me of 28c	. Injury at Work?	28d. Describe f	low injury oc	curred	
2 F F F E	atic	2 Accident investig	ation Found 11-2	6-05 Found	4.4	1 ☐ Yes 2 No	i	inkno	Wn	
	100	3 ☐ Suicide 6 ♣ Could n 4 ☐ Homicide determi	1000 UI III	jury - At home, farr tc. (Specify)	n, street, factory, o	office	28f. Location (5 City or Tox	Street and Nu		I Route Number.
Atte			Found i		ant how	us o	Street	Baltin	308 E.	Lafayetto
Lal or Atters at Director	Cert		g Physician: To the best	of my knowledge,	death occurred at	the time, date and place my opinion, death occu	e, and due to the	cause(s) and	manner as si	tated.
DIVISION DIVISION OF THE POUR STREET OF THE POUR ST	cal Certification:	29a. Certifier 1 Certifyin		OALITHITATION CITA	o. mroonganon, m	iniy opinion, Louin oode	21.00 21 11.0 111.10,	auto una pia	00, 4114 440 10	110 00000(0)
DIVISION OF VITAL RECORDS, the Hospital or Attending Physician: The law requires thin 24 hours after death. The Funeral Director: After this certificate has been signed pletally filled in by the funeral director, page 2 should be	edicai	(Check only 2XX Medical i	and manner st	ated.	00. 1			10 1 0 1 1	1 (14	O V 1
DIVISION Of VITAI HECORDS, P.O. BOX of To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as		(Check only 2XX) edical i	and manner st	ated.	29c. L	icense number		29d. Date sig	gned (Month,	Day, Year)
To the Hospital or Atte within 24 hours after des To the Funeral Directon completaly filled in by th	edicai	(Check only 2XX Medical i	and manner st	ated.	29c. l	OCME			gned (Month, er 28.	
DIVIS To the Hospital or Atte within 24 hours after des To the Funeral Directol completaly filled in by th	edicai	(Check only 2XX Medical i	and manner st		Type, Print)			Novemb	er 28.	2005

			1- State Registrar Amend Items 2981	ewizyanzhanzh [Certifica	ME, GUSTION te of Death	Middle Market Ma	giene 005	43766
×	Physic /Medi	cal	1. Decedent's Name (First, Middle, Last) Theodore To 4a. Facility Name (If not institution, give street an	ylor	41.60	-	2. Date of De Month Novem	ber 23,20	05 14:10AM
4 45	Examile Funeral Director	ner	Johns Hopkins Bayuren 5. Social Security Number 131-22-5612 Sex 12 M 20	Medical Cer 7. Age (In yrs. ias	ater &	y, Town, or Location of Calt MO er 1 Year If Under 2 s Days Hours	re	ay, Year)	
	death with the Maryland ms 23a or 28a-1 show I must be notified at	or	Usual Residence of Decedent 10a. State 10b. County MD		own or Location				10d. Inside City Limits 1 √ Yes 2 □ No
	or 28a-	Direct	10e. Street and Number	Dai		ip Code		10g. Citizen of What C	
920	after or its	by Funeral Director	1 ☐ Never Married 2 ☒ Married 1 ☐ \\ If Ye	Decedent Ever in U.S. of Forces? fes 2 XNo s, Give or Dates:		21224 edent of Hispanic Original Proof of Hispan	in? (Specify Yes or No Puerto Rican, etc.)	USA 14. Race - Am Black, Wh Specify: W	ite, etc.
21215-0036	within 72 ho ene. then "natur he Medical	Completed	15. Decedent's Education (Specify only highest grade completed in the complete state of	ted) ge (1-4or 5+)	16a. Decedent's Us (Give kind of v life. DO NOT college p	vork done during most use retired)	of working	16b. Kind of Business	,
Maryland 2	ould be filed Mental Hygi arked other atic event,	To Be Co	17. Father's Name (First, Middle, Last) Theodore Taylor Sr		correge	18. Mother	s Nam <i>e (First, Middle</i> Virginia	, Maiden Sumame)	IOII
Baltimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Menla Hygiene Important: if Item 27 is marked other then "naturel", important: if Item 27 is marked other then "naturel", any injury or other traumatic event, the Medical Example.		19a. Informant's Name/Relationship (Type, Print) Virginia Taylor/spous 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal 1 4 ☒ Donation 5 □ Other (Specify)	e 20b. Place		t Avenue B		er, City or Town, State, \(\begin{align*} \limits 21224 \\ 20c. Location - City of the content of the c	<u> </u>
Balt	permit. Pa Departmen Important: eny injury once.		21. Signature Funeral Service licensee Ronald S. Wade	prector	State	and Address of Facility Anatomy Bo	ard 655 W. 1201	Baltimore	Street
	Physician /Medical		23a. Part1. Enter the disease, or complications t shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	hat caused the death. [on each line.	onot enter the mo		ardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
8760,	physicien and interpretations in the burial-transit	dical Examiner	Sequentially list conditions, from any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	e to (or as a consequen	ce of):	ritonea	I hul		7 months
P.O. Box 687	The law requires that the dsath certificate are has been signed by the stlending phy page 2 should be detached for use as the	Physician/Medic	in the past 12 months?	, outcome of pregnancy ive birth 2 ☐ Fetal de regnant at time of death nknown	ath 3 □Ectopic	pregnancy	ON APPROVED BY MEB	23d. Date of de Month	livery Day Year
ds, P	uires that n signed b	þ	Part II. Other significant conditions contributing Normal pressure hydro	to death but not resultin cephalus, v	ig in the underlying V entricul	cause given in Part I. O-peritone	23e. Did to	obacco use contribute to	the cause of death?
Division of Vital Records,	n: The law require ficate has been sij r. page 2 should b	Completed	shunt				24a. Was autor perfo 1 Yes	an 24b. Were an prior to death? 2 No 1 \(\text{Yes} \)	utopsy findings available completion of cause of
of Vit	hysicier his certii il directo	To Be			/Outpatient 3□ D	0.4	f Death Check only of ing Home 5 Resid	ne) dence 6 □Other (Spe	cify)
ion	ath. r: After e funera	atlon;	27. Manner of Death ***Thetural 5 Pending 2 Accident investigation Nov	Month, Day Year)	b. Time of Injury iknown м	28c. Injury at Work? 1 ☐ Yes 2 🛣 No		now injury occurred	
Divis	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	OCIO : : : Could not be	lace of Injury - At home uilding, etc. (Specify) at home	, farm, street, facto	ry, office	City or Tov	Street and Number or Right, State)	
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one) Certifying Physician: To the control one one one one one one one one one one	the best of my knowled ne basis of examination manner stated.	dge, death occurre and/or investigatio	d at the time, date and n, in my opinion, death	place, and due to the occurred at the time,	cause(s) and manner as date and place, and due	s stated. to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	0	29	c. License number		29d. Date signed (Mont	h, Dey, Year)
			30. Name and address of person who implied	cause of death (Item 23	a) (Type, Print)	JHH#T	11+7 1	Voveinber	23,2005
	100 S	10	Violette Renard 40 31. Date filed Month. Day. Year 6	40 Easte	rn Aven	ue, Balt	more, Ma.	yland 2	n, Dey, Year) 23, 2005 1224
	Sta Registr		JAN 1 8 2006	My Mi My				185	

			State of Maryland / Department of Health and 1- State Amend Items 25,27,28a-f per ME 6851.01/12/06dhb	Mental Hyg	giene 005	5 43767
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Dea Month	ıth	3. Time of Death
	/Media	cal	James Howard Walts	Novemi	per 29 6	2005 9: 10 PM
	Examir	ier	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea BALLIMORO MAMERICAL CLUTER BALLIMORO MAME	ath	4c. County pf	Death 2
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr			Birthplace (State or Foreign Country)
	Director		191-8-1921 A. S. Yrs.	May 17,	1924 P	ennsylvania
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	a-f eh	ctor	Maryland Baltimore Lansdowne			1 ☐ Yes 2 🔯 No
	or 28	Director	10e. Street and Number 10f. Zip Code	1	log. Citizen of Wha	
	filed within 72 hours after death with the Maryland Hygiene ther then "natural", or Items 23a or 28a-1 ehow ont, the Medical Examination Le rodified at	Funerai	915 Catawba Court 21227 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ((Chasifu Van ar Na	United	States American Indian,
9	after d	Fun	Armed Forces? If Yes, specify Cuban, Mexican, Puè 1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No	erto Rican, etc.)		White, etc.
003	ural',	d by	3 Wildowed 4 Divorced Year or Dates: WII . VIET		Specify:	White
15-	in 72 t	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of well file. DO NOT use retired)	orking	16b. Kind of Busin	ness/Industry
212	d with giene. rr ther	omb	8 College (1-4or 5+) truck driver		transp	ortation
Maryland 21215-0036	e d a s	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	ame (First, Middle, I	Maiden Sumame)	
Z∃a		은				
Na	2 6 9 2		19a. Informant's Name/Relationship (Type, Print) Mary Watts - wife 19b. Mailing Address (Street and Number or Fig. 19b. Mail			
Ē,	of Health Item 27 other tr		20a. Method of Disposition 20b. Place of Disposition (Name of		20c. Location - Cit	
imo	Pages ment of I ent: If Ite		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory, Inc. 11	/30/05	Baltimor	e. Maryland
Baltimore,	permit. Page Department Importent: If any injury of once.		21. Signature of Funeral Service bicensee 22. Name and Address of Facility H	lubbard Fu	neral Ho	me, Inc.
	0.0 = 8 O		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia		<u>-</u>	-
	Filysician	6	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ac or respiratory arre	est,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Due to ("r" is a consequence of):			3 days
	Examiner		Sequentially list conditions, b. traymana wan mury	7		6 weeks
-	ted nsit	nine	Sequentially list conditions, if any leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events c.	1		
Ć.	be executed ician and burial-transit	Examiner		WEDICAL EXAMINE	R	
8760,	cate be executed physician and the burial-transit	dicai	Due to (or as a consequence of): CERTIFICATION APPROVED B	A WEDIOLE D.		
9	n certifica anding pl use as t	/Med	IF FEMALE:			
Вох	atte	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No. 4 Pregnant at time of death 5 Other (specify)		23d. Date of Month	f delivery Day Year
0	that the de ed by the detached	hysi	1 Yes 2 No 9 Unknown 9 Unknown			
S,	es ngi	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	pacco use contribu	te to the cause of death?
ord	w require	eted		1 🗆 Ye	es 2,25No 3[Probably 4 Unknown
Records,	The taw zate has t page 2 s	Completed		24a. Was ar autops perform	y prior	e autopsy findings available to completion of cause of h?
Vital		a	25. Was case referred to medical 26. Place of De	1 ☐ Yes 2	No 1 🗆	
	ys di	ToB	examiner?	Home 5 Reside		Specify)
Division of	ing P	ion:	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 10/18/2005 9:30 P.M. 1 Yes 2 No.		w injury occurred	wn stairs
isic	Attend death ctor: , y the f	ficat	3 Suicide 6 Could not be 28e. Place of Injury - At home farm street factory office			r Rural Route Number,
2	el or / s after il Dire	Certification:	4 Homicide determined determined building, etc. (Specify)	915 Cata	wba Ct.	Landsdowne, MD
	To the Hospitel or Attending Physicien: whithis 24 hours after deals. To the Funerel Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only (Ch	e, and due to the ca urred at the time, da	tuse(s) and manne	or as stated. due to the cause(s)
	othe othe omple	Med	one) and manner stated. 29b. Signature and title of certifier 29c. License number		9d. Date signed (M	
}	- s - ō		Menden S. Datis P18546			
		-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Windy S. Oatts 10NGREENE Street B)		
,			31. Date filed (Month, Day, Year) 32. Registrar's Signature	ALTMURE	MD 21	201
	Sta Registra		JAN 1 2 2006			

	1 - For State Registrar	State of Mary	land / Dep		Health and		_	43768
, and the second	1. Decedent's Name (First, Middle, La	ist)				2. Date of Dea Month	th Day Year	3. Time of Death
sician edical	HASSAN AGHILI			1		DECEMBER		13:15 M
niner	4a. Facility Name (If not institution, give	e street and number)			or Location of Dea	ith	4c. County of Deat	TGOMERY
	5. Social Security Number 6. S	Sex 7. Age (In	yrs. last birthday,	If Under 1 Year				hplace (State or Foreign untry)
		1⊠M 2□F	91 Yrs.	Months Days	Hours Mir	10/07/19	14 IRA	N
tor	MD 10b. County MONTGO		c. City, Town or L		ANTONW			10d. Inside City Limits 1 🛣 es 2 🗌 No
Funeral Director	10e. Street and Number			10f. Zip Code	2007/		l 0g. Citizen of What Co	
era	14101 GALLOP TERM	ACE 12. Was Decedent Ever	in U.S. 13.	Was Decedent of	20874			
by Fun	1 Never Married 2X Married	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cul 1 ☐ Yes 2X No		Specify Yes or No- into Rican, etc.)		e, etc. HITE
Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)	16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retir	upation e during most of w ed)	orking	16b. Kind of Business/	Industry
E D	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		DLONEL	,		IRANIAN AR	MY
Be						ame (First, Middle, BEH "UNKNO		
ဥ	19a. Informant's Nama/Relationship FARIBORZ AGHILI-			•		Rural Route Number	r, City or Town, State, 2	Zip Code)
	20a. Method of Disposition	2	Ob. Place of Disp			Date	20c. Location - City or	Town, State
	1 Burial 2 ☐ Cremation 3 (4 ☐ Donation 5 ☐ Other (Spec	Removal from State	•		- F	31/2005 I	ROCKVILLE,	MARYLAND
	21. Signature of Fundal Service Lice		2	2 Name and Add	ross of Facility		L CHAPELS,	
	23a. P. int. Enter the issasse, or consock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	nplications that caused the yone cause on each line. a. END STAGE Due to (or as a co	DEMENTI		ying, such as cardi	ac or respiratory ari	rest,	Approximate Interval Between Onset and Death YEARS
cal Examiner		b. Due to (or as a ex	insequariou of):					
Physician/Medic		23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	□Ectopic pregnan	ісу		23d. Date of de Month	livery Day Year
<u>۾</u>	Fatt II. Other significant conditions	contributing to death but n	ot resulting in the	underlying cause g	given in Part I.		obacco use contribute to res 2 √No 3 ☐ Pi	o the cause of death?
Completed						24a. Was autop perfor 1 Tyes	sy prior to death?	utopsy findings available completion of cause of
Bec	25. Was case referred to medical			- The state of the		eath Check only o	ne)	
P	1 ☐ Yes 2 ☑ No	1 Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatie 28b. Time Injury	of 28c. In			lence 6 X Other (Spe	ocity) HOSPICE
Certification:	3 Suicide 6 Could not 4 Homicide determine	be 290 Place of Injury	- At home, farm, s Specify)			281. Location (S City or Tow	Street and Number or R m, State)	ural Route Number,
Medical		Try sician: To the best of a aminer: On the basis of ex and manner stated	amination and/or i	ith senumed at the nvestigation, in my	time, dats and play opinion, death oc	coursed at the time, o	date and place, and due	s stated e to the cause(s)
Me	29b. Signature and title of certifier	ul		29c. Lice D42	nse number 452		December	
	30. Name and address of per on who DR. RAJA GOPAZ,		FR MILL	RD. ROCK	VILLE, M	D 20850	7.511	
State istrar	TENER B /2 21	Registrar's	Signature	ules				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Edwin S. Armstrong December 28 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Deer Ridge Manor Rising Sun Cecil If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 F Director 221-03-9796 April 17,1913 Wilmington, DE Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show or most be notified at 1 Yes 2 No Director New Castle Wilmington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a 2003 Limestone Road 19808 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ZYes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married altimore, Maryland 21215-0036 6 white 1 Yes 2 No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced nature the Mudical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Worker General Motors other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental marked Edwin S. Armstrong, Sr. Anna Somers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Haalth Alva W. Hemshrot (niece) 101 West Green Lane Milfrod, DE 19963 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 Burial 2 □ Cremation 3 □ Removal from State Date 20c. Location - City or Town, State Pages Depertment of Importent: if any injury or once. 4 □ Donation 5 □ Other (Specify) Gracelawn Mem. Park | 12/31/2005 New Castle, DE 21. Signature of Funeral Service Licenses, N. 00766 22. Name and Address of Facility McCrery Funeral Homes, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardiomy spathy 7 scheemic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires thet the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical îhe ettending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) ad by the e Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 sl autopsy 20X No 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No death. 4 hours after death Funerei Director; / 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funerei C

completely filled i To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Decamber 30, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6+IVA Seasons Hospice 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 20b per 1h 8852 2-7-06 vt.

			For State Registrar	State o	f Marylar		artment rtificate			d Mental	Hygien	71115	43770
	Physici	an	1. Decedent's Name (First, Middle	, Last)					_	2. Date of	of Death	av Year	3. Time of Death
	/Medic		William Amos 1							DEC	EMBER	"30, 2005	7:34 P M
	Examir	er	4a. Facility Name (If not institution,		mber)				ocation of De	ath	4	Ic. County of Deat	
			6223 LIVINGSTON				OXON						GEORGES CO
	Funeral Director		5. Social Security Number	6. Sex 1 M 2 ☐ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Months I	Days	If Under 24 H Hours M	in. (Monti	n, Day, Yea	(r) Co	hplace (State or Foreign untry)
			579-08-9570 Usual Residence of Decedent		_27					11-	-29-78) <u>1</u>	OC
	anyland ehow		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	Mar B-f-et	Director	MD Prince	e Georges	0x	on Hill	L						1 Yes 2 □ No
	or 28.	lrec	10e. Street and Number				10f. Zip C	ode			10g. C	Citizen of What Co	untry?
	th wi	alD	1515 Fenwood Av	enue/			20	745				United S	States
	r dea	Funeral	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U		Was Deceder	nt of Hisp Cuban,	oanic Origin? Mexican, Pu	(Specify Yes o	or No-	14. Race - Ame Black, White	
36	or It	by Fu	1 Never Married 2 Marri	ied 1 XXYes If Yes, Giv	2 □ No /e ates: 96 - 0(1	1 ☐ Yes 2		Specify:			Specify: B1a	
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or Iteme 23a or 28a-1 ehow ha Madical Examinar must be politied at	D D	3 Widowed 4 Divorced		ates: 96-0		dent's Usual (2000-001			105		
5	in 72	Completed	(Specify only highes	t grade completed)		(Give	kind of work DO NOT use	done dui retired)	ring most of a	vorking	160.	Kind of Business/	industry
212	iene.	E	Elementary/Secondary (0-12) 1 2	College (1	!-4or 5+)		oer App				Plu	mbing Co	mpany
b	be filed within 72 hours after death with the Maryla ital Hygiene. Industrie, or liteme 23s or 28s-1 ehow of other then "neture!, or liteme 23s or 28s-1 ehow event, the Medical Examiner must be netiling at	Be C	17. Father's Name (First, Middle, L	ast)		1 2 2 3 1 1				lame (First, Mi	ddle, Maide	en Sumame)	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other then eumatic event, in M	To B	William A. Brow	m, Jr.					Debor	ah A. A	anders	son	
any	s 1 and 2 should f Health and Men Item 27 le marke other treumatic		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Maitir	ng Address (S	Street an	d Number or	Rural Route N	u <i>mber, Cit</i> y	or Town, State, Z	ip Code)
	다 2 등 명		Deborah A. Ande	erson/Moth		_			venue,	Oxon I	Hill,	MD 20745	5
Baltimore,	ges 1 al t of Hea If Item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from	_ (Place of Dispo cemetery, cr <u>e</u> r	natory or other	er place)		Date		Location - City or	Town, State
Ë			4 □Donation 5 □ Other (Sp		Mar	yland 4	eteran	S Ceme	tery 0	1-09-06	Che	eltenham,	
Sall	permit. Pa Departmer Important eny injury		21. Signature of Funeral Service L	igensee L								ıneral Se	
	40 E • 0		rock. A	wickle	and							rings, MI	
			23a. Part1. Enter the disease, or shock, or heart failure. List of	only one cause on e	aused the deal			, ,					Approximate Interval Between Onset and Death
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a	tillti		7UW	sho	+ WO	and.	<u>S</u>		
	Examiner		, and the second	Due to (or as a consec	quence of):							
		<u>a</u>	Sequentially list conditions, if any, leading to immediate	b. ————————————————————————————————————	or as a consec	quence of):				·			
	unsit	E	cause. Enter Underlying Cause (Disease or injury		•								
Ć.	exection and items	Examiner	that initiated events resulting in death) Last	C. Due to (or as a consec	quence of):							
68760,	cate be executed physicien and s the burial-transit	dlcal		d									
_		00 1											
Вох	death certifi e attending i id for use es	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna		Ectopic preg	nancy				23d. Date of deli	,
	0 0 0	Physician/M	in the past 12 months? 1 □ Yes 2 □ No		ant at time of c		Other (spec				-	Month	Day Year
P.0	at the ded by the etached	Phy	9 Unknown							1			
	The law requires that the ste has been signed by th bage 2 should be detache	ρ	Part II. Other significant condition	As contributing to de	eath but not res	sulting in the ui	nderlying cau	se given	in Part I.			Y°	the cause of death?
oro	w requir been s should	Completed								-	1 ☐ Yes	2 Ø No 3 □ Pro	bbably 4 Unknown
Sec.	e law has b	du								- 1	Mas an autopsy	prior to d	topsy findings available ompletion of cause of
<u>=</u>											erformed? es 2□N	death? lo 1/2 Yes	2 No
Vital Records,	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				0		eath (Check o		v	CCENE
o	Phys r this ral di	- 10	U\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	28a. Date o		28b. Time of		1	4 🗀 Nursing			6 Other (Specury occurred	SCENE SCENE
on	ding h. After funer	ton	1 Natural 5 Pending 2 Accident investig	Mont	h Day Year)	Frund	OM LO	lnjury a Work? 1 □ Ye	s 2 XNo	200. 0030	2. 6.		+
Division	or Attending ifter death. Director: After in by the fune	flca	3 Suicide 6 Could n	not be 28e. Place	of Injury - At h	ome, farm, str	1			28f. Locati	on (Street a	and Number or Ru	ral Route Number,
Ö	after I Direct d in by	Certification:	4 Homicide determi	buildir	ng, etc. (Specii	sollC	_			City o.	Town, Sta	(0) 6223	Livingstank
	To the Hospitel or within 24 hours after To the Funerel Director Completely filled in b	alc	29a. Certifier 1 ☐ Certifying	g Physician: To the	best of my kno	owledge, death	occurred at	the time,	, date and pla	ce, and due to	the cause(s) and manner as	stated.
	n 24 he Fu	edical	(Check only one)	Examiner: On the ba and mann	asis of examina ner stated.	ation and/or in	vestigation, in	my opin	nion, death od	curred at the ti	me, date ar	nd place, and due	to the cause(s)
	To the within 2 To the comple	ž	29b. Signature and title of certifier	1000		,		icense n				ate signed (Month	
,			larde	Halla	uma	1		J J			DEC	CEMBER 31	, 2005
D	(10)		30. Name and address of person y	who completed caus	e of death (Iter	n 23a) (Type,	Print)	CTD	EET D	ΔΙ.ΤΤΜΟΙ	DE MA	ARYLAND,	21.201
1	-(')		31. Date filed (Month, Day, Year)	1111	egistrar's Signa		T THINK	DIL		TITIOL	TIF	**************************************	21201
	Sta Registr		IAN 0 5 21			Son	R						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Joseph Battle 25, 2005 8:00 A M /Medical December 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7051 Carroll Ave. #204 Takoma Park Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1⊠M 2□F Director 227-16-2107 17 84 1921 VA Nov. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "netural", or Items 23e or 28e-f ahow 10a State 10b. County 10c. City, Town or Location ral', or Itams 23e or 28e-f ahow Exertiner must be notified at 10d. Inside City Limits 1 ☐ Yes ŽINo Directo Maryland Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7051 Carroll Ave.# 204 20912 Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Black Specify: 3 ₩ Widowed 4 Divorced other traumatic avant, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Pavillion Apartments 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Battle Beulah Nelson ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Kibler/Niece 6905 Asset Dr. Hyattsville, MD 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ō Department of Important: If any injury or once. Fort Lincoln Cemetery 12/30/2005 Brentwood, MD 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** disease or condition resulting in death) ongesti 48025 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): To the Hospital or Attanding Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): use as the burial-P.O. Box 68760, attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) the 9☐ Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Be Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 \ Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No **Diractor**: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 23392 December 30, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue, Ste. 606, Kensington, Und. 20895 Connecticut 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryla		artmen <i>rtificat</i>			nd Me	ntal Hy	/gien Reg. N		15	43112
	Dhusia		1. Decedent's Name (First, Middle, Las.	1)						Date of Do		ay Y	ear_	3. Time of Death
	Physici /Medi		Anna Mae Berger							Month Decemb			05	3:28 p ^M
1	Examir	er	4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or L	ocation of l	Death		40	c. County of	Death	
			Holy Cross Hospit		Land to instead and	Silve If Under	r Spi	ring If Under 24	Hrs o	Date of Bi	rth.	Montg	ome:	ry
	Funeral		5. Social Security Number 6. Se 10		s. last birthday) O Yrs.	Months			Min.	(Month, D.	av. Year))5 W		ace (State or Foreign try) ington, DC
	Director		Usual Residence of Decedent						1	ay J,	131	J 1	asii.	ingcon, be
	/land		10a. State 10b. County	10c. 0	ity, Town or Lo						_		10	Od. Inside City Limits
	Mar	ţō	Maryland Montgom	ery	Kensin	gton								1 ☐ Yes 2 No
	3a or 28	Funeral Director	10e. Street and Number 3616 Littledale	Road		10f. Zip	Code 0895				10g. C	itizen of Wha	s A	try?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Heelth and Mental Hygiens. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Modical Examirat must be notified at	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes, Give Year or Dates:		Was Deced If Yes, spec		panic Origir , Mexican, F Specify:	n? (Specif Puerto Ric	y Yes or No	0-	14. Race - Black, 1 Specify:	White, e	etc.
21215-0036	ture sture	be d	15. Decedent's Ed	ucation	16a. Dece	dent's Usua	I Occupati	ion			16b. l	Kind of Busin	ess/ind	lustry
	- M	Completed	(Specify only highest grad	de completed) College (1-4or 5+)	(Give	kind of wo DO NOT us	rk done du se retired)	ring most o	f working					
212	d within plene. ir then "	ē	12	Odliego (1-401-34)	Retai	.1 Sal	es/Ho	omemak	cer		Own	n Busi	nes	s/Own Home
Þ	otho	Bec	17. Father's Name (First, Middle, Last)				1	18. Mother's	s Name (I	irst, Middle	, Maide	n Sumame)		
<u>la</u>	vid b Menta	To	Enrico Ferraro					Lauı	ra Da	y				
Maryland	nd 2 sho eith and 1 27 ie ma ir traume		19a. informant's Name/Relationship (7 Edward J. Berger/			•	•					or Town, Sta Beach		_{Соde)} E 1 9930
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Heelih and Mental Hygiene. Important: If Item 27 is marked other then ery injury or other traumatic event, Ins. Ma. 2006.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Souther (Specify	Removal from State	Place of Dispo cemetery, cre-	matory or o	ther place)		Jan Dat On 2	6, 006		ocation - Cit	•	
Balti	Depermit. Depertmine importal eny injuly once.		21. Signature of Funeral Service Licens		2: F	2. Name an	d Address	of Facility	ins F	unera W, S	1 H	ome In	C	, MD 20901
	cate be executed /Medical Examiner the burial-transit	dical Examiner	23a. Part1. Enter the disease, or compshook, or heart failure. List only commediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Acute Renal Due to (or as a consect. Due to (or as a consect.) Due to (or as a consect.) Due to (or as a consect.) Due to (or as a consect.)	Failur equence of): ar Necr equence of):	e							1	Interval Between Onset and Death I Week Week
	death certiff e attending id for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	□Ectopic pr □ Other (sp						23d. Date o Month		ry Day Year
	equires that the sen signed by th ould be detache		Part II. Other significant conditions co	ontributing to death but not re	esulting in the u	inderlying c	ause given	n in Part I.						e cause of death?
Records,	sician: The law req certificate has been irector, page 2 shou	Completed							_		psy ormed?	dea	re autop r to corr th? Yes	osy findings available opletion of cause of
	uificat cor, p	8	25. Was case referred to medical					26. Place of	f Death ((1 ☐ Yes	25€ N		103	20140
5	Physician: this certific ral director,	ToB	examiner? 1 ☐ Yes 2x ☐ No	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3□ D0	Othor					6 □Other (Specify)
	iding Physi th. : After this c funeral din													
Division	To the Hospitel or Attending is within 24 hours atten death. To the Funeral Director: After completely filled in by the funer	27. Manner of Death 1 Shatural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury 1 Yes 2 No 28d. Describe how injury 28d. Discribe how i										or Rural	Route Number,	
	Nospite 24 hours Funerel letely fille	Medical C	29a. Certifier (Check only one) 1.3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										ated. the cause(s)	
	Poth Within To th comp	Me	29b. Signature and title of confier	replace				9834			Jar	ate signed (A luary		
_			30. Name and address of person who o Barry Rosenbaum,	completed cause of death (It M.D 3720 F	em 23a) (Type, arragut	Print) Aven	ue, k	Kensin	ngton	, MD	2089	95		
	Sta	te	31. Date filed (Month, Day, Year)	32. Prigistrar's Sig	nature	berte	0							

			1 - For State Registrar		of Maryland		artment rtificate			and M		Reg. N	. 00	5	437	73
	Physici	an	Decedent's Name (First, Mide								2. Date of D Month		ay	Year	3. Time of	Death
	/Media		Janet Louise								Decemb				6:59	_9 ^M
	Examir	er	4a. Facility Name (If not institution						Location of				c. County o			
			19310 Club H				Ga1		sburg If Under		0 0-1		Montgo			
	Funeral		5. Social Security Number 017–34–0457	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. Ia	ist <i>birtnaay)</i> Yrs.	Months	Days	Hours	Min.	8. Date of B (Month, L April	av. Yea	r)	Cou	place (State ontry) achuse	_
	Director		Usual Residence of Decedent	Λ	02						APLII	10,	1945 ['lass	acruse	LLS
	/land		10a. State 10b. Count	ty	10c. City,	Town or Lo	cation							T	10d. Inside C	ity Limits
	Man f sh	ģ	Maryland Mon	tgomery		Gaith	ersbu	ra							1 Tyes	2 X No
	r 28g	irec	10e. Street and Number		<u> </u>	*	10f. Zip					10g. C	itizen of W	hat Cou	ntry?	
	h witl	Funeral Director	217 Booth St.	, Apt. 110			2	0878				U	S.A.			
	deed	ner	11. Marital Status	12. Was Dec	cedent Ever in U.S	3. 13.	Was Deced	ent of Hi	spanic Orig	gin? (Sp	ecify Yes or N Rican, etc.)	lo-		- Ameri	can Indian,	
9	or ite	교	1 Never Married 2 Ma		27 No ive		1 ☐ Yes 2			, , , ,	7110411, 010.7		Specify:			
5-0036	72 hours after deeth with the Maryland "natural", or Items 23e or 28e-f show idical Examiner must be notified at	d by	3 ☐Widowed 4 ☐ Divorce	ed Year or I	Dates:			245				,				
5	- × 34	Completed		ent's Education lest grade completed,		16a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occupa k done d	ation Juring most	t of work	ing	16b.	Kind of Bus	iness/In	idustry	
121	withir ane. then	E G	Elementary/Secondary (0-12)	College (1-4or 5+)		hic P					17	C C	~1 Y ~ ~	mmont	
d 21	filed within Hygiene. other then "		17. Father's Name (First, Middle	9, Last)	1	Grap	IIIC P.	roce		r's Nam	e (First, Middl		.S. Go on Surname		Interic	
an	d be and a company of the company of	9 Be	Leroy E.	Gorton							у J .		ffin	,		
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, the M	2	19a. Informant's Name/Relation			19b. Mailir	na Address	(Street a			al Route Num			tate. Zii	Code)	
Ma	id 2 s ith an 27 is treu		Susan E. Kleb		hter		-				d., Bro	-				। उ
ā,	ges 1 and 2 should be filed withir it of Health and Mental Hygiene. If Item 27 is marked other than or other treumatic event, the M		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Nam	ne of	Cricipe		Date	_	Location - C			
Baltimore,	Pages nent of the ant: If its arry or o		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		State Mar	metery, crei yland	natory or ot Vete	her place rang	"Jan	5+3 / ~	,2006	524			_	
Ϊ	pernit. Page Dep. rtment Importent: If any injury or once.		21. Signature of Funeral Service		1101		2. Name and				2	_Ch	eltenk	iant.	Maryl	and
Ba	permit. Departr Importe any inje		2-12	M	M00668	W	illia	ms F	unera	il Ho	ome, P.	Α.	_			
	- 10- 19		23a. Part1. Enter the disease, shock, or heart follure. Li	or complications at		4	270 Ha	awth	orne a. such as	Rd.	India or respiratory	n He	ead, N	/d	Approximat	9
		П	shock, or neart follure. List Immediate Cau-Tinal	st only one cause on	- (,				Interval Bet Onset and	ween
	Physician /Medical		disease or condition resulting in death)	a U	Shick	101	Dile	WY	NON	a				-	NOU	5
	Examiner	ш		Due to	(or s a consequ	ence or):	laic	Onl	× D.	i r hat	- > C				-10-10	
		- e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a conseque	ence of):	SVIC	Aca	cupo	T.C.	217			-	Year	>
	s be executed siclen and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury	1					70							
,	execu n and ai-tra	Exa	that initiated events resulting in death) Last	c Due to	(or as a consequ	ence of):										
8760,	cate be executed physiclen and the burial-transit	dicail		d.												
9	ificat g phy as th	edi														
Box	that the death certific ed by the attending p detached for use as	N/M	IF FEMALE: 23b. Was decedent pregnant		itcome of pregnan		7e						23d. Date	of deliv	ery	
	death e atte	icia	in the past 12 months? 1 ☐ Yes ☐ Ne-	4□Preg	birth 2 ☐ Fetal nant at time of de		∃Ectopic pre ∃ Other (spe						Mont	h	Day '	Year
0	t the by th	hys	9 Unknown	9∐Unkr	nown											
о, О	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	by Physician/Me	Part II. Other significant condi	tions contributing to	death but not resul	lting in the u	nderlying ca	ause give	n in Part I.		23e. Did	tobacco	use contrib	oute to t	he cause of o	leath?
rd	w require been sig should b	pa									1 🗆	Yes :	2 □ No 3	Prot	bably O	inknown
CO	as been 2 should	Completed									24a. Wa		24b. W	ere auto	psy findings impletion of c	available
Ä	The lav	E									per 1 Tyes	opsy formed?	de	ath?	2 No	ause of
Vital Records,		a	25. Was case referred to medic	cal			··		26. Place	of Deat	h (Check only					
>	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes ₩ No	Hospital: 1	Inpatient 2 E	R/Outpatier	nt 3□ DO	A Othe	er: 4 □ Nu	rsing Ho	me 5 Res	sidence	Other	(Specil	Assis Livinپلان	red
J of	ding Ph h. After thi funeral	Ë	27. Manner of Death ☐ Natural 5 ☐ Pend	28a. Date	of Injury oth, Day Year)	28b. Time o Injury	f 21	Bc. Injury Work			28d. Describe		_			
0	Attendir death. ctor: Af y the fur	atic	2 Accident inves	stigation		,,	М		res 2 🗆 i	No						
Division	of or Attend effer death Director: /	Certification;	3 ☐ Suicide 6 ☐ Coul. 4 ☐ Homicide deter	d not be mined 28e. Plac build	e of Injury - At hor ling, etc. (Specify)	me, farm, str	eet, factory	, office			28f. Location City or To	(Street a	and Number te)	or Rura	al Route Num	ber,
	To the Hospitel or Attending within 24 hours efter death. To the Funerel Director: After completely filled in by the fune															
	losp hon uner uner	edicai	29a. Certifier 1 Sertify (Check only 2 Medical	ring Physician: To the l al Examiner: On the l	e best of my know pasis of examinati	vledge, deat	h occurred a	at the tim	e, date and	d place, th occuri	and due to the	e cause(s) and man	ner as s	tated.	()
	the H the F the F	ledi	one)	and mar	nner stated.											
	T W T CO	Σ	29b. Signature and title of certif	house	AU.		29c	. License	- 0	1		29d. D	ate signed	(Month,		25
			> yacc	mond	() (D			D 3	3139	1		DC	C	-	20	05
5	S(2, 1.)		30. Name and address of perso	on who completed cau	se of death (Item	23а) (Туре,	Print)								20850)
d	DID		s. Abulfar	ag, M.D.	, 1521	5 Sha	ıdy G	rov	e Rd	•,_	Suit 1	00,	Rock	vil	Iĕ,	ld.
	Sta		31. Date med (worth), Day, 166	0 C 2000	Registrar's Signate	ure K	Sorell	1								
	Registi	a!	JAN	0 6 2008	The Control of the Co	~ /	-									

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) December 23, 2005 Physician Roderick Cole Sr. Wallace 1448 hrs. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 1**X** M 2□ F 75 Yrs Director 418-32-3670 August 25,1930 Alabama Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "netural", or items 23s or 28s-f ehow the Madical Examiner must be notified at 1X Yes 2 No Washington Director District of Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20018 4205 - 19th Place, N. E. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Marned Specify: Black 1 ☐ Yes 2X No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done du life. DO NOT use retired) U.S. Government Elementary/Secondary (0-12) College (1-4or 5+) Printing Office 2 years Printer f Health and Mental Hyg Item 27 is marked other other trsumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Willie Co1e Luvater Garrett 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Elizabeth Jackson Cole 4205 - 19th Place, N.E.; Washington, D.C. 20018 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dec. 30, 2005 5 ■ Burial 2 Cremation 3 Removal from State Department of Important: if any injury or once. National Harmony Memorial Park Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service/Licensee 22 Name and Address of Facility R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS JUNDROMB Physician /Medical TUDE SIDE INFECTION. Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit Due to (or as a consequence of) Be Completed by Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ACUTE ON CHRONIC RENTAL FAIWLE, MAINUTAIDON 1 Yes No 3 Probably 4 Unknown HYPERGLYLEMIA, CEREBROWASCULAR ACCIDENT, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an PRESSURE SURE RIGHT ANKLE. performed? HADEFLENCION 20 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death | Check only one) Hospital:

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.
To the Funerel Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Certifying Physician: To the heat of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R. Suyansundar 753367 12/24/2001

State Registrar

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

99

Pages 1 and 2 should

The law requires that the death certificate be executed

To the Hospitel or Attending Physician:

After

Division of Vital Records, P.O. Box 68760,

if item 27 i

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHYAMSUMMA . LATHW

DHMH 17 Rev 1/2001

			For State Registrar	State	of Maryla		artment of H rtificate of I		d Mental H	ygiene Reg. No.	UUD	43775
	Physici		1. Decedent's Name (First, Midde Virginia Mae Cl						2. Date of I Month 12	Death Day 29	2005	3. Time of Death 2:55 A M
),	/Medio Examin		4a. Facility Name (If not institution 803 Arcadia S	=	umber)	- 57	4b. City, Town, or Easton,		Peath		County of Death	<u> </u>
	Funeral Director		5. Social Security Number 218–40–6104	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yi	rs. last birthday) 62 Yrs.	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of E Min. (Month, I 04-22	Birth Day, Year) -1943	Cou	place (State or Foreign intry) 11and
	Aaryland I show	or	Usual Residence of Decedent 10a. State 10b. Count MD Talbe	,		City, Town or Lo						10d. Inside City Limits 1 ☑ Yes 2 ☑ No
	sa or 28a-	i Director	10e. Street and Number 803 Arcadia S	t			10f. Zip Code 21601			10g. Citi	zen of What Cou	intry?
920	be filed within 72 hours atter death with the Maryland tal Hyglene. Id other than "natural", or Items 23a or 28s-1 show other than "natural", or Items 23a or 28s-1 show event, the Medical Evantinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Ma 3CFWidowed 4 Divorce	12. Was De Armed F rried 1 Yes	2 ∑ No live		Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	ispanic Origini in, Mexican, Pi Specify:	? (Specify Yes or Nuerto Rican, etc.)	No-	14. Race - Ameri Black, White Specify: B1a	, etc.
Maryland 21215-0036	within 72 hou ene. than "nature he Medical E	Completed	15. Decede (Specify only high Elementary/Secondary (0-12) 10th	nt's Education est grade completed College	(1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of l)	working		nd of Business/Ir	
land 2	should be filed to dental Hygis marked other i matic event, II	To Be Co	17. Father's Name (First, Middle Perry Roberts	, Last)		131110	WOLKEL		Name (First, Midd Sullivan			ry roods
	and and s m		19a. Informant's Name/Relation Joseph Allen /		ı	111	ng Address (Street a				r Town, State, Zi	p Code)
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If Item 27 I any injury or other tra QDCB.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 1 ☑ Donation 5 ☐ Other (n State	cemetery, crei	osition (Name of matory or other place n Memoria	· 1	Date 1/07/06	_	cation - City or T	own, State
Balt	permit. Departr Import. any inj		21. Sign ture of Funeral Service	la K	nund	<i>э</i> В		th Fun			Dover S	21601 St. Easton,M
	rnysician /Medical Examiner		23a. Part 1. Enter the disease shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a Due to	o (or s a cons	equence of):	er the mode of dyin			arrest,		Approximate Interval Between Onset and Death
58760,	icate be executed physician and s the burial-transit	dical Examiner	r any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	o (or as a cons							
.O. Box (the death certil y the attending iched for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	utcome of preg birth 2 Te gnant at time o nown	etal death 3	⊒Ectopic pregnancy ☐ Other (specify)			2	23d. Date of deliv Month	ery Day Year
ecords, P	w requires that been signed b should be deta	by	Part II. Other significant condit	ions contributing to	death but not r	esulting in the u	nderlying cause give	en in Part I.		l tobacco u] Yes 21		the cause of death?
α	The law ate has b page 2 sl	Completed							24a. Wa aut per 1 □ Yes	opsy formed?	prior to co death?	opsy findings available impletion of cause of
f Vital	Physician: This certificatal director, p	To Be	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital:	Inpatient 2	☐ ER/Outpatier	nt 3 DOA Othe	200	Death (Check only		S □Other (Speci	fv)
sion of	Miter			ing (Mo tigation	of Injury nth, Day Year)	28b. Time o Injury	Work		28d. Describe			
Division		Certification;	4 Hornicide	mined 286. Flac	ding, etc. (Spe	cify)	eet, factory, office		City or To	own, State))	al Route Number,
	To the Hospital or within 24 hours ette To the Funeral Dir completely filled in	Medical	(Check only 2 Medica	773	ne best of my k basis of exami nner stated.	nowledge, deat nation and/or in	vestigation, in my or	oinion, death o	ace, and due to the occurred at the time	, date and	place, and due t	o the cause(s)
)	T wit		29b. Signature and title of certifi	STA	W.	D	29c. License	7,50	,	290. Date	e signed (Month,	Day, Teal()
	t cc			n who completed car anchez, M.	D., 5	08 Idle	Print) wild Ave.	. East	on.Marvla	and 21	/ L601	
	Sta Registr		31. Date filed (Month Pay, Xea	5 2006	Registrar's Sig	nature.	est.					

1 - For State Registrar			ertificate of	Health and f Death		Reg. No.	05	4377	6			
Decedent's Name (First, Middle, L	_ '				2. Date of De Month	Day	Year	3. Time of Dea	ith			
al	CATTERTON	J	T # 65 T		Decemb		200		М			
er 4a. Facility Name (If not institution, gr		- 1		or Location of Dea	ith		inty of Death 4ょち					
THE MEMORIA 5. Social Security Number 6.		HC (In yrs. last birthda			s. 8. Date of Bit			place (State or Fo	reian			
579-54-2071 Usual Residence of Decedent	1□M 2 X F	62 Yrs.	Months Day	's Hours Mir	s. 8. Date of Bit (Month, Date SEPT 8	, 1943		RGINIA				
10a. State 10b. County		10c. City, Town or	Location					10d. fnside City Li	mits			
KAT CM Ş	LBOT	E	ASTON					1 Yes 2	No			
MD TAI 10e. Street and Number			10f. Zip Code			10g. Citizen		intry?				
411 S. HARRISON				21601	Canada Van er Ne		USA.	ione ledine				
11. Marital Status 1 Never Married 2 Married	12. Was Decedent 8 Armed Forces? 1 Yes 2		If Yes, specify Cu	if Hispanic Origin? (uban, Mexican, Pue	rto Rican, etc.)	14.	Race - Ameri Black, White					
3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣N	lo Specify:		Spe	ecify:	HITE				
15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 11	Education	16a. Dec	edent's Usual Occ	cupation	orkina	16b. Kind o	f Business/Ir	ndustry				
Elementary/Secondary (0-12)	College (1-4or 5	+)		ne during most of w ired)	9		U.S. GOVERNMENT					
	0	PO	STAL WORK		ama (First Middle							
<u> </u>	,				Y SMITH	, 10.2.2017 0077						
HENRY RULEY 19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	iling Address (Stre	et and Number or F		er, City or To	wn, State, Zi	ip Code)				
JODI L. ZELENY	DAUGHTER	120	33 THREE	BRIDGE B	RANCH RD	, CORD	OVA, M	D 21625				
	Oa. Method of Disposition 1											
	(A)	CHECADE	AKE CREMA	ATTON CTR	12/28/2	በበ5 ሮሞ	FVFNCV	TITE MD				
4 Donation 5 Other (Spec		7										
21. Signature of Funeral Service Lic	ensee . MER	EROD	FELLOWS, 200 S. H	HELFENBE ARRISON S	IN & NEW T EASTON	NAM FU , MD 2		HOME PA				
21. Signature of Funeral Service Lic	mplications that caused	EROD the death. Do not e	FELLOWS, 200 S. H	HELFENBE ARRISON S	IN & NEW T EASTON	NAM FU , MD 2			n			
21. Signature of Funeral Service Lic	mplications that caused y one cause on each lin	EROD the death. Do not e	FELLOWS, 200 S. H	HELFENBE ARRISON S	IN & NEW T EASTON	NAM FU , MD 2		HOME PA Approximate Interval Between	n			
21. Signature of Funeral Service Lic 23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that caused y one cause on each lin	the death. Do not ene.	PELLOWS, 200 S. Hanner the mode of d	HELFENBE ARRISON S	IN & NEW T EASTON	NAM FU , MD 2		HOME PA Approximate Interval Between	n			
21. Signature of Funeral Service Lic 23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Esquantially list conditions, if any leading to immediate	mplications that caused y one cause on each lin	the death. Do not ene.	PELLOWS, 200 S. Hanner the mode of d	HELFENBE ARRISON S	IN & NEW T EASTON	NAM FU , MD 2		HOME PA Approximate Interval Between	n			
23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Esquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	mplications that caused y one cause on each lin a	the death. Do not end.	PELLOWS, 200 S. Hanner the mode of d	HELFENBE ARRISON S tying, such as cardi	IN & NEW T EASTON	NAM FU , MD 2		HOME PA Approximate Interval Between	n			
23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Saguantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	mplications that caused y one cause on each lin a	the death. Do not end.	PELLOWS AND ADDRES	HELFENBE ARRISON S tying, such as cardi	IN & NEW T EASTON	NAM FU , MD 2		HOME PA Approximate Interval Between	n			
23a. Part1. Enter the disease, or coshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	mplications that caused y one cause on each lin a	the death. Do not end. a consequence of): a consequence of):	PELLOWS AND ADDRES	HELFENBE ARRISON S tying, such as cardi	IN & NEW T EASTON	NAM FU.	NERAL 1601	Approximate Interval Between Onset and Deat 4 months of the Minnt	n			
21. Signature of Funeral Service Lic 23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	mplications that caused y one cause on each lin a. Due to (or as a Due to (or a) Du	the death. Do not end. a consequence of): a consequence of): of pregnancy 2 Fetal death	PECTOPIC pregnan	HELFENBE ARRISON S tying, such as cardi	IN & NEW T EASTON	NAM FU.		Approximate Interval Between Onset and Deat 4 months of the Minnt	n			
23a. Part. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Esquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	mplications that caused y one cause on each lin a. Due to (or as: Due to (or as: Due to (or as: Due to (or as: C. Due to (or as:	the death. Do not end. a consequence of): a consequence of): of pregnancy 2 Fetal death	PELLOWS 200 S. Hu Inter the mode of d Only Carcin	HELFENBE ARRISON S tying, such as cardi	IN & NEW T EASTON	NAM FU.	NERAL 1601	Approximate Interval Between Onset and Deat Honorth Minnst	n			
23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Saquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	mplications that caused y one cause on each lin a. Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as:	the death. Do not ene. a consequence of): a consequence of): of pregnancy 2 Fetal death time of death	PECTOPIC pregnates	drass of Facility BE ARRISON S trying, such as cardi	IN & NEW T EASTON ac or respiratory a	NAM FU. , MD 2	NERAL 1601 Date of defive Month	Approximate Interval Between Onset and Deat Honorth Minnst	23 24 16:			
23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions	mplications that caused y one cause on each lin a. Due to (or as: Due to (or as: Due to (or as: C. Due to (or as: d. 23c. ff yes, outcome 1	the death. Do not ene. a consequence of): a consequence of): of pregnancy 2 Fetal death time of death ut not resulting in the	PECTOPIC pregnates	drass of Facility BE ARRISON S trying, such as cardi	T EASTON ac or respiratory a	NAM FU. , MD 2	Date of defive Month	Approximate Interval Between Onset and Deat Honorth Manager Honorth	123 144.1:			
23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sagusnitially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	mplications that caused y one cause on each lin a. Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as:	the death. Do not ene. a consequence of): a consequence of): of pregnancy 2 Fetal death time of death ut not resulting in the	PECTOPIC pregnates	drass of Facility BE ARRISON S trying, such as cardi	IN & NEW T EASTON ac or respiratory a 23e. Did 1 24a. Was auto	NAM FU. Amount of the second	Date of defive Month sontribute to a 3 pro	Approximate Interval Between Onset and Deat Hannat Manager Hannat	th:			
23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions	mplications that caused y one cause on each lin a. Due to (or as: Due to (or as: Due to (or as: C. Due to (or as: d. 23c. ff yes, outcome 1	the death. Do not ene. a consequence of): a consequence of): of pregnancy 2 Fetal death time of death ut not resulting in the	PECTOPIC pregnates	ress of Each to HELFENBE ARRISON S stying, such as carding the second se	IN & NEW T EASTON ac or respiratory a 23e. Did 1 24a. Was auto perf, 1 Yes	NAM FULL Trest, 23d. tobacco use of Yes 2 No. an 24 promed? 24 No.	Date of defive Month contribute to a 3 Pro	Approximate Interval Between Onset and Deat Hannat Manager Hannat	th:			
23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Saquentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	mplications that caused y one cause on each lin a. Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as: Due to (or as:	the death. Do not ene. a consequence of): a consequence of): of pregnancy 2 Fetal death time of death ut not resulting in the	PELLOWS AND ADDRESS OF THE PROPERTY OF THE PRO	ress of Eaching HELFENBE ARRISON S trying, such as cardinated as cardina	23e. Did 24a. Was auto perfu	ves 2 No	Date of defive Month Contribute to the prior to condeath? 1 Yes	Approximate Interval Between Onset and Deat Hono The Man And Hono The Hono	th:			
23a. Part. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Esquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months? 1 Yes 2 No 9 Unknown	mplications that caused y one cause on each linual to the property of the prop	a consequence of): a consequence of): a consequence of): of pregnancy 2 Fetal death time of death ut not resulting in the	PECTOPIC pregnate of decision of the control of the	drass of Eaching HELF ENBE ARRISON S trying, such as cardinate as card	IN & NEW T EASTON ac or respiratory a 23e. Did 1 24a. Was auto perf, 1 Yes	tobacco use of Yes 2 No one)	Date of defive Month Contribute to the service of	Approximate Interval Between Onset and Deat Hono The Man And Hono The Hono	th:			
23a. Part. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Esquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months? 1 Yes 2 No 9 Unknown	mplications that caused y one cause on each ling. a. Due to (or as: Due to (or a	a consequence of): a consequence of): of pregnancy 2 Fetal death time of death ut not resulting in the	PETLOWS HAVE TO THE PROPERTY OF THE PROPERTY O	ress of Eachity HELFENBE ARRISON S trying, such as cardi	23e. Did 24a. Was auto perfu	tobacco use of Yes 2 No one)	Date of defive Month Contribute to the service of	Approximate Interval Between Onset and Deat Hono The Man And Hono The Hono	th:			
23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes No No No No No No No No	mplications that caused y one cause on each line. a. Due to (or as: Due to (or a	the death. Do not ene. a consequence of): a consequence of): of pregnancy 2 Fetal death time of death ut not resulting in the series of the property of	PETLOWS AND ADDRESS OF THE ADDRESS O	given in Part f. 26. Place of D. Other: 4 \(\text{ Nursing} \) Nursing at Vork? \(\text{ Yes} \) 2 \(\text{ No} \)	23e. Did 23e. Did 24a. Was auto perful yes 28d. Describe 28f. Location (tobacco use of Yes 2 No one) idence 6 how injury oc	Date of defive Month Date of defive Month	Approximate Interval Between Onset and Deat Hono The Man And Hono The Hono	th:			

-10-

State Registrar

30. Name ress of person to completed cause of death (ftem 23a) (Type, Print)

JONN P. MASTANDRSA SOG TOLEWILD AVE EASTON MID 2160

31. Date filed (Month, Day Year) 2005

32. Registrar's Signature

DEC 2 9 2005



MD



D36644

12-28-2005

			For State Registrar	State of Mary	land / Dep			Mental Hy	_	43777					
			1. Decedent's Name (First, Middle, L	ast)				2. Date of De		3. Time of Death					
	Physicia /Medic Examin	al	Saint Jean 4a. Facility Name (If not institution, g.	ive street and number)		Cha 4b. City, Tow	rles m, or Location of Death	Month	Day Year 2005 4c. County of Dea						
150	Funeral		Anchorage Nursing 5. Social Security Number 6.		tion Ctr	y) If Under 1 Y	ear If Under 24 Hrs.	8. Date of Bi	th 9. Bi	rthplace (State or Foreign ountry)					
harl	Director		589-07-0605 Usual Residence of Decedent	x⊠ ^{M 2□ F} 67	Yrs.	Months Da	ays Hours Min.	June 24	, 1938 Hai	ti					
6	ylanc How		10a. State 10b. County	100	c. City, Town or	Location				10d. Inside City Limits					
C	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It of Health and Mental Hygiene. It filem 27 is marked other then "natural", or Itema 23s or 28s-f show or other traumatic event, the Medical Examinar must be notified at	Director	Maryland Wicomi	CO	Salisbu	10f. Zip Coo	de		10g. Citizen of What C	Na 2 No					
_	with so as		540 P : 111 G						-						
34	ne 23	era	510 Priscilla Stree	12. Was Decedent Ever	in U.S. 13		of Hispanic Origin? (St	ecify Yes or No	USA - 14. Race - Am	erican Indian.					
	fter d	Funeral	1 Never Married 2 Married	Armed Forces?		If Yes, specify (of Hispanic Origin? (Sp Cuban, Mexican, Puerto	Rican, etc.)		te, etc.					
J. 0036	hours after tural', or Ite	Þ.	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣	No Specify:		Specify: Ha						
	2 hou	Completed	15. Decedent's	Education	16a. Dec	cedent's Usual Oc	ccupation		16b. Kind of Business	BCK s/Industry					
+ 215	within 72 ene. then "na'	ple	(Specify only highest g	rade completed) College (1-4or 5+)	(Gin	ve kind of work do . DO NOT use re	one during most of work attred)	king							
213	filed with Hygiene ither the	E	12	College (1-407 5+)	labo	rer			Farm Ind	ustry					
	Hygid other	Bec	17. Father's Name (First, Middle, Las	st)			18. Mother's Nam	e (First, Middle	, Maiden Sumame)						
SA	should be ind Mental i marked o umatic eve	ToB	Charlus			arles		ie (unk							
A ref	2 shc and ls m		19a. Informant's Name/Relationship						er, City or Town, State,	Zip Code)					
2	Health of Health ltem 27		Gesner Charles/so				Street - Sa	CHIEF TO THE PARTY OF THE PARTY		21801					
ore	of H	- 1	20a. Method of Disposition 1∑ Burial 2 ☐ Cremation 3		Ob. Place of Dis cemetery, cr	position (Name o rematory or other	place)	Date	20c. Location - City or	Town, State					
Ĕ	nit. Pag artment ortant: I Injury c		4 □ Donation 5 □ Other (Spec		ohn Wes	sley Cem	etery 12/18	3/2005	Princess An	ne, Maryland					
Baltimore	permit. Page Department of Important: If eny Injury or once.		21. Signature of Funeral Service Lice	B. Jalle			ddress of Facility 121			llisbury, MD 21801					
	Physician :		23a. Part1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition												
	/Medical		resulting in death)	Due to (or as a co		KATION	THEONO	114		4 WPS					
	Examiner	l r	CVA												
	8-25	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Uniterlying												
	uted d ansit	ᇤ	Cause (Disease or injury that initiated events		N	EUROSY	PHILIS			2 4195					
0	te be executed ysicien and he burial-transit	Examiner	resulting in death) Last	Due to (or as a co	nsequence of):					700					
3760	ite be iysicii ne bu	cal		d											
89	leath certifical attending phy	Physician/Med	IF FEMALE:												
Вох	ath ce	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐		B Ectopic pregna	ancy		23d. Date of de Month	Day Year					
	e de	Sic	1 Yes 2 No	4 Pregnant at time 9 Unknown	of death 5	Other (specif)	y)		World	ouy rour					
P.O.	that the de ted by the a	Ph		and the standards but any				00- 0:4		- the of d					
U.	The law requires that the death certificate has been signed by the attending phage 2 should be detached for use as the	þ	Part II. Other significant conditions	contributing to death but no	it resulting in the	underlying cause	e given in Part I.		obacco use contribute t	robably 4 Unknown					
orc	w requires t been signe should be	Completed						''	162 202140 301	Tobably 4 Dorkinskii					
e c	e law has b	npi						24a. Was auto	prior to	utopsy findings available completion of cause of					
-	The tate has page	S							ormed? death?	s 2 No					
/ita	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?				26. Place of Deal	th (Check only	one)						
<u></u>	Physi this c	၉	1 ☐ Yes 2 Ø No		2 ER/Outpati	ient 3 DOA	Other: 4 Nursing Ho	ome 5 Resi	dence 6 Other (Spe	ecity)					
	ng P	.io	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time Injury	of 28c.	Injury at Work?	28d. Describe	how injury occurred						
0	Attending ir death. ector: After by the fune	2 Accident investigation M 1 Yes 2 No													
Division of Vital Records.	or Attending P after death. I Director: After t d in by the funera	27. Manper of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred								ural Route Number,					
	urs a														
	To the Hospital of within 24 hours at To the Funeral D completely filled in	29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Mouth 5)													
	To the within To the	Me	29b. Signature and title of certifier			29c. Lic	cense number		29d. Date signed (Mon	th, Day, Year)					
	->	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, III) 0 57359 DIC 12/5 20								005					
			30. Name and address of person who		(Item 23a) (Tuo				yeu ip.	4					
			1415 - 5 DIVIS	JON ST. SA	LISBUR	YI MD X	sha Nates	an		40					
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	/	-								
	Registra		DEC 14	2005 Malesan	B. B.	parte									

			For State Registrar	State of Marylar	•	rtificate of		-	Reg. No.	105	43778					
	Physici	an	Decedent's Name (First, Middle, Last)	- El Di	151		-	2. Date of De Month	Dav	Year	3. Time of Death					
	/Medic	al	Devan 4a. Facility Name (If not institution, give s		az	Ab City Town o	r Location of Death	DEC.	25, 2	005 ounty of Death	15:50 P ^M					
	Examin	er	2107 QUEENS CHAPEL			HYATTS				INCE G	EORGES					
	Funeral Director		5. Social Security Number 6. Sex		last birthday) Yrs.	If Under 1 Year Months Days	Il Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Octobe)	th ly, Year)19	28 9. Birthp	place (State or Fourign htty) West idad, Indies					
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation					IOd. Inside City Limits					
	Maryli f eho	Ď	Maryland Prince G		Hyattsv						1 X Yes 2□No					
	or 28a	Director	10e. Street and Number	0		10f. Zip Code			10g. Citizer	of What Cour	ntry?					
	ath will	raiD	2107 Queens Chap			207					st Indies					
9500-61212	be filed within 72 hours atter death with the Maryland ital Hyglene. d other then "naturel", or iteme 23a or 28a-f ehow event, the Medical Examinat must be redified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 🖫 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No		pecify Yes or No o Rican, etc.)		Race - Americ Black, White, pecify: B1						
, D	72 ho	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor	rking	16b. Kind	of Business/In	dustry					
7	within 72 ene. then *nat	Completed by	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+)		DO NOT use retired Lectricia			E1e	ctric	Company					
	Hygie other	Be Co	17. Father's Name (First, Middle, Last)		1 2		18. Mother's Nar	ne (First, Middle								
yland		To B	Norbert Diaz				Lilli	an Ch	arles							
Mar	0 0 0		19a. Informant's Name/Relationship (Typ		1	ng Address (Street										
و' و	1 and 2 Heelth tem 27 a		Adela Bernadette R 20a. Method of Disposition	20b.	Place of Dispo	sition (Name of				on, D.C						
פֿר	Peges nent of int: If it iry or o		1 ☐ Burial 2 【ACremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, crer	natory or other place ke Cremat	ı	5,2006								
Baitimore,	permit. Peges 1 Department of H Important: If ite eny injury or ott		21. Signatur 3 Funeral Service License	A	22	Name and Addre	ss of Facility Comp	any Mort	ician	s, Inc.	Maryland					
			23a. Part1. Enter the disease, or complik	cations that caused the dea		600 Kenne er the mode of dyin				gton,D.	Approximate					
	Physician		shock, or heart failure. List only one cause on each line. Interval Between Onset and Death													
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hyperthusive atheroscientic (ardiovascular Due to (or as a consequence of):													
	LXammer	20	Sequentially list conditions,													
	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury													
ĵ	exect en and rial-tra		that initiated events c resulting in death) Last	Due to (or as a conse	quence ol):			-								
68/60,	rificate be executed og physicien and es the burial-transit	Aedicai	€ d													
	5 00		IF FEMALE:	3c. If yes, outcome of pregn	ancy											
X Q Q	death cert le attendin ed for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fet	al death 3	Ectopic pregnancy Other (specify)	1		230	I. Date of delive Month	ory Day Year					
r Ö	at the de by the a stached f	hysi	9 Unknown	9□ Unknown												
	gned go de		Part II. Other significant conditions con								he cause of death?					
0	w require been si should I	ted	Chronic obstr	active pu	iu one	19 dis	ich	1 🗆	Yes 2 1	No 3 ☐ Prob	pabiy 4 Unknown					
Vital Records,	: The law cete has b page 2 si	Completed by			-	·		24a. Was		24b. Were auto prior to co death?	ppsy findings available mpletion of cause of					
ē		င္ပ	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes	2 No	1 ☐ Yes	2□ No					
>	Attending Physician: r death. ector: After this certific by the funeral director,	0 0	ayaminar?	ospital: 1 Inpatient 2] ER/Outpatier	nt 3 DOA Oth				Other (Specif	AT SCENE					
0	ng Ph fter th ineral	T :uo	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	l 28c. Injur Wor		28d. Describe			,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
<u>s</u>	or Attending Fiter death. Irector: After a by the funera	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	1		Yes 2 □No	2011								
Division of	i Pite	Certification:	4 Homicide determined	City or To	wn, State)		al Route Number,									
	- '4 - O	Medical	29a. Certifier (Check only one)	sicien: To the best of my kn ner: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	, and due to the gred at the time,	date and pla	d manner as s ace, and due to	tated. the cause(s)					
	To the	Me	255. Data digital in the state of the state													
1	(2)		· lahilla	242-		0.0	C.M.E		DEC.	27,200)					
_	20		30. Name and address of person who co			Print) TREET, BA	TTTMODE	MADVI AND	0100	1						
L	Sta	to	ZABILLEAT A 31. Date liled (Month, Day, Year)	32. Registrar's Sign		TITLE DA	TTTTIVKE,	LINIX T LINIV	0 2120	T.						
П	Sta Regista		JAN 0 6 200		4 4	made a										

			For	State of Maryla				-	ene						
			1 - State Registrar		Cei	rtificate of L	Death	Re	g. No. UU5	43/19					
П	Physici	an	1. Decedent's Name (First, Middle, Las	t)		,		2. Date of Death Month	Dav Year	3. Time of Death					
	/Medic		Lonard Nathan					Decembe	r 31 2005						
	Examin	er	4a. Facility Name (If not institution, give				Location of Death		4c. County of Dea						
			Anne Arundel Med 5. Social Security Number 6. Se		rs. last birthday)	Annapo If Under 1 Year	L1S If Under 24 Hrs.	8. Date of Birth	Anne Ar						
	Funeral Director			Vu and	85 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, July 11,		thplace (State or Foreign ountry) nnessee					
	P .		Usual Residence of Decedent						1,00	,					
	show	_	10a. State 10b. County		City, Town or Lo	cation				10d. Inside City Limits					
	28e-f	ectc	MD Anne Ar	undel	Crofton	10f. Zip Code		10	g. Citizen of What C						
	with Me or	급	1714 Truro Road			2111	4		USA	ourity ?					
	death ms 2;	by Funeral Director	11. Marital Status	12. Was Decedent Ever in	n U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	14. Race - Am						
9	after or ite	Ξ	1 ☐ Never Married 2 🛣 Married	Armed Forces? 1 X Yes 2 □ No If Yes, Give 104			n, mexican, Puerto Specify:	Hican, etc.)	Black, Whi	te, etc. White					
8	within 72 hours after death with the Maryland ene. then "neturei", or items 23e or 28e-f show the Medical Exam for must be notified at	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: 194	3-07										
<u>-</u>	"net	lete	15. Decedent's Edi (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual Occupa kind of work done o DO NOT use retired	ation <i>furing m</i> ost of work)	ing 1	6b. Kind of Business	/Industry					
77	l withi	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		icer	,	1	U.S. Army						
ğ	Hyg other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M							
<u>/lar</u>	uld be Menta Irrked	To B	Lon Victory Davis				Edith Mi	lan							
Maryland 21215-0036	and and is m		19a. Informant's Name/Relationship (7			-			City or Town, State,	Zip Code)					
	l and tealth im 27		Jane M. Davis (Wi			Truro Ro				Tours Chate					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Importent: if item 27 is marked other then "neturel; or items 23e or 28e-f show any injury or other treumatic event, the Mudical Examination in all the rolling of any once.		1 ☐ Burial 2 X Cremation 3 ☐	memoval num state		sition (Name of natory or other place	1	-	Oc. Location - City or						
Ħ.	artme artme ortent injury		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Service License		letro Cro		1/3/2		altimore,	MD					
Ba	Depa impo any ir		Datal A	aull		Name and Addres Hardesty 12 Ridge	Funeral	Home, P.	A. 1is, MD 2	1401					
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the d	eath. Do not ent					Approximate Interval Between					
	Physician		Immediate Cause (Final disease or condition	1	ma f	e. June				Onset and Death					
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):											
		_	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. End Sha	sequence of):	mphyse.									
	uted 1 ansit	Examiner	Cause (Disease or injury	_											
o Î	exectan an an an an an an an an an an an an a		that initiated events resulting in death) Last	Due to (or as a cons	sequence of):										
8760,	death certificate be executed e attending physician and of for use as the buriat-transit	Ical		d											
9	entifica ling p	Physician/Med	IF FEMALE:	00-16											
Вох	leath certific attending p	lan	in the past 12 months?	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Nivery Day Year					
P.O.	that the de ned by the a detached f	nyslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	ordeall 3										
	The law requires that the site has been signed by the page 2 should be detache	by Pł	Part II. Other significant conditions co	ontributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute t	o the cause of death?					
Records,	w require been sig should b							1-40	2 □ No 3 □ P	robably 4 Dunknown					
ecc	e taw requ has been je 2 shouli	Completed						24a. Was an		utopsy findings available completion of cause of					
		Con						perform	ed? death? No 1 ☐ Yes						
Vital	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		045		h (Check only one							
o	Phys rthis ral dii	-: To	1 Yes 2 45	28a. Date of Injury	2 ER/Outpatier 28b. Time o	f 28c. Injury		me 5 ☐ Resider 28d. Describe hov	nce 6 Other (Spe	acify)					
O	nding th. : Afte s fune	tlor	1 ■Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year	r) Injury	Work	(?` Yes 2 ∐ No		· many document						
Division	i or Attendi after death. Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury · A building, etc. (Spe	At home, farm, str	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or R	ural Route Number,					
ā	itai or rs afte ai Dir led in	Cert	4 - Homeda	Building, atc. (Spi	ecity)			City of Town,	State)						
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	(Check only 2 Medical Exam	ysician: To the best of my liner: On the basis of exam	knowledge, deat nination and/or in	h occurred at the time vestigation, in my or	e, date and place, pinion, death occur	and due to the cared at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)					
	thin 2 the omplet	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number	29	d. Date signed (Mon	th. Dav. Year)					
)	₹ <u>₹ 8</u>		M. u	/ \	- mc	2 1000	57625	- /	2000 L.	31,2005					
			30. Name and address of person who d	completed cause of death (Item 23a) (Type.	Print)			1.						
			I'm Worns	2001 1	nedica	1 Park	uny	Anny	whis me	31,2005					
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Si	ignatur <i>e</i>	-			-						
	negisti	(a)	A-2- CO.												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepen Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** W. Dashiel 2130 P M wood 12 03 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE 6. Sex at Salisbur Maryland the Lake oastal If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2□F Yrs. 217-30-7782 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show other treumatic event, the Madical Examiner must be notified at 1XYes 2 □ No Completed by Funeral Director Maryland icomico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21875 noac 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Yes 2 No Army 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 💆 No Specify: Year or Dates: Black 3 XWidowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be I and Mental F Pages 1 and 2 should be 2 lurne 19a. Informant's Name/Relationship (Type, Print), 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Stage Koberta ompanion 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 0 1 Burial 2 □ Chemation 3 □ R 4 □ Donation 5 ☑ Other (Specify) 3 Removal from State permit. Page Depertment of Important: If any injury or Veterans 71)40-414nd 22. Name and Address of Facility Isabella Street 917 W. Maryland 2/80 Smith Funeral Home tennic Part1. Enter I shock, or hea e disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Onset and Dead Immediate Cause (Final disease or condition resulting in death) **Physician** 110/03/01/ 6 month ance /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-transit to the Hospitel or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. by Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ete has been signed by the atte page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🗆 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan 1 ☐ Yes 1 TYes Division of Vital Be 25. Was case referred to medical examiner? director 26. Place of Death | Check only Hospital: Other: Certification: To 1 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Late of Injury (Month, Day 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifer 29d. Date signed (Month, Day, Year) 26278

Registrar

30. Name and address_of person who completed

oceall

Salista

use of death (Item 23a) (Type, Print)

costal Hospice

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month December Lucille Elizabeth Epps 28, 2005 11:03 PMM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Montgomery Arden Courts Assisted Living Silver Spring If Under 1 Year | If Under 24 Hrs.
Months Days Hours | Min. 8. Date of Birth (Month, Day, Year) Sept. 1, 1915 9. Birthplace (State or Foreign Country)
Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 1 ☐ M 2 🔀 F 90 121-20-4741 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2505 Musgrove Road 20904 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Pearl Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6206 Darrowberry Ct. Glenn Dale, MD. 20769 Gail Epps / niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Barnabas Cemetery 12/31/2005 Upper Marlboro, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD. ow 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis 1 week disease or condition resulting in death) Due to (or as a consequence of): Dementia 5 yrs. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 TYes 25. Was case referred to medical examiner? Assisted 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify)Living 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43237 Dec. 29, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14201 Laurel Park Dr. Laurel, MD.

Examiner The law requires that the death certificate be executed and as the burialthe attending physician Division of Vital Records, P.O. Box 68760 use ō funeral After Hospital or Attending after death. | Director: Af within 24 hours a To tha Funaral D

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Exeminer must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Eventinal Once.

Physician

/Medical

Examiner

Physician/Medical

Completed

Be

P

Certification:

Medical

Baltimore, Maryland 21215-0036

death with the Maryland

State Registrar

DHMH 17 Rev 1/2001

Paul Armstrong, M.D. 31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Vaar 26, PHILIP JOSEPH EMMERMAN DECEMBER 2005 8:49 P. /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner SUBURBAN HOSPITAL MONTGOMERY BETHESDA If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 017-34-9196 60 21, 1945 MASSACHUSETTS Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show or other traumatic event, the Medical Examiner must be notified at **BETHESDA** MARYLAND MONTGOMERY by Funeral Director 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after deeth with til Department of Health and Mental Hygiene. Importent: If them 27 is marked other then "naturel", or iteme 23a or 2 and the injury or other treumatic event, the Medical Examination of once. 7906 LYNNBROOK DRIVE 20814 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PROFESSIONAL MECH. ENGINEER U. S. GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) IRVIN EMMERMAN 2 FRANCIS GLOVSKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRISTINA B. EMMERMAN - WIFE 7906 LYNNBROOK DRIVE, BETHESDA, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State NATIONAL CREMATORY 12/30/2005 FALLS CHURCH, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND Donald 20852 23a. Part 1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ventricular Fibrillation Physician /Medical Due to (or as a consequence of) Examiner Infarction MYOCAFOIT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed for use as the burial-transil that initiated events resulting in death) Last and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 D:5-6456 1 Yes 2 No 3 Probably 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? this certificate has 2 No 2 No 1 Yes ours after death.

Nerel Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 🗌 Inpatient ER/Outpatient 3 DOA 27. Mannet of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 Tes 2 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide within 24 hours a 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier pletely (Check only onel To the 29b. Signature and tale of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54776 Emergency Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 OLD GEORGETOWN ROAD, BETHESDA, MARYLAND 20814 Barton -eonard MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 06 2006 Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Пач **Physician** Month Year **JEROME** FRANCIS FLETCHER 11:15 A M DECEMBER 25. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6403 Hil-Mar Drive District Heights Prince George's Il Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 5, 1953 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral X**□M 2□F 215-64-5815 52 Maryland Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location r than "natural", or Itams 23s or 28s-f show the Medical Examinar must be notified at 10d. Inside City Limits 1 →Yes 2 □ No Director Maryland Prince George's District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 6403 Hil-Mar Drive 20747 United States death 12. Was Decedent Ever in U.S. Ameed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates:VIETNAM à Specify. 3 ☐ Widowed 4 ☐ Divorced Black. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) 12th College (1-4or 5+) Auto. Mechanic 12 should ba filed w h and Mental Hygier 7 is markad othar th Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Francis Fletcher Marion Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 siment of Health an Valerie Fletcher/Wife 6403 Hil-Mar Drive, District Heights, MD 20747 othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ŏ 1 XBurial 2 Cremation 3 Removal from State parmit. Page Department Important: If any injury or Maryland Veterans Cem. 1/4/2006 Cheltenham, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1. E te the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Approximate Interval Between Immediate Car se (Final disease or con the n resulting in death) Onset and Death Priysician a CHRONIC OBSTRUCTIVE PULMONARY DISEASE /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examine certificate be executed the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed by I should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ PULMONARY HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed TALC GRANULOMATOSIS 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performe 2 **X**No 1 Yes Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: After 1 XNatural 5 Pending after death. investigation M 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funaral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tille of certifie 29c. License number 29d. Date signed (Month, Day, Year) #MD 34143 **DECEMBER 27, 2005** 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 JENNIFER P. BAPTISTE, M.D., VAMC 50 IRVING STREET NW, WASHINGTON, DC 20422/688 32. Registrar's Sir nature 31. Date liled (Month, Day, Year) State JAN 0 6 2006 Registrar

13784

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Depertment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural; or items 23s or 28s-f show and hyginy or other traumatic event, the Madical Exacultant containing an one.

Physic /Med Exam

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1 = Stete Registrar	Cer	tificate of L	Death		Re	g. No.	000	90109	
	1. Decedent's Name (First, Middle, Last)				- 2	2. Date of Death Month	Day	Vasa	3. Time of Death	
ian ical	Edward N. Fitzgibbon				D	ecember	· 30	, 2005	11:00 A M	
ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location					h	
	121 Huse Drive			Annap	olis			Anne	Arundel	
	5. Social Security Number 6. Sex 7. Age (In yrs. last bin		If Under 1 Year Months Days	If Under Hours	24 Hrs. 8	B. Date of Birth (Month, Day,	Year)	9. Birt	hplace (State or Foreign	
	3//-44-3323 121 /2	Yrs.				ept. 28				
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Loc	cation							
5		01 200		\nnar	olic			In od. Inside City Limits I Yes MRNo In of What Country? U.S.A. Race - American Indian, Black, White, etc. pecify: White In of Business/Industry Company Imame) Town, State, Zip Code) Ind 21403 Ition - City or Town, State Colis, Maryland Funeral Home Interval Between Onset and Death 12 months In occupant of delivery Month Day Year In occupant of death? No 3 Probably 4 Munknown In occupant occ		
ectc	Maryland Anne Arundel			Annap	OTIS					
Director	10e. Street and Number		10f. Zip Code	24.40		10	0g. Citiz		•	
rai	121 Huse Drive			2140						
nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Or ın, Mexica	igin? (Spec n, Puerto R	rty Yes or No- ican, etc.)	1			
×	1 ☐ Yes 2 ☐ No If Yes, Give X 3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	1	☐Yes 21 No	Specify:				Specify: V	Mite	
Completed by Funeral		Deced	ent's Usual Occupa	ation			ICh Kin	d of Business	Seducte:	
let	(Specify only highest grade completed)	(Give I	kind of work done of NOT use retired	durina mos	at of working	7	IOD, Nin	d of business	industry	
Ĕ	Elementary/Secondary (0-12) College (1-4or 5+)		ount Exe	•	7O		ЗМ	Compar	357	
ŭ	17. Father's Name (First, Middle, Last)	ncc	Oure Lac			First, Middle, N			<u> </u>	
Be	John Fitzgibbon, Sr.					Timmor				
မ		Mailin	a Address (Street)	and Numb				Tour State	Zin Codo)	
			Huse Dri							
	the state of the s	_	sition (Name of	1	Da	COLUMN TO THE PARTY OF THE PART				
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ry, crem	atory or other plac							
	4 Donation 5 Other (Specify) St. Ma		s Cemete		1/4/2					
	21. Signatura de l'une rai de l'ucensee									
	Jove Estates	-						аротт		
	23a. Part1. Enter the disease, or complications that caused the death. Do r shock, or heart failure. List only one cause on each line.	not ente	er the mode of dyin	g, such as	cardiac or	respiratory arre	est,		Interval Between	
	Immediate Cause (Final disease or condition a. Non-small cell	l lu	ing cance	r						
	resulting in death) Due to (or as a consequence									
L	Sequentially list conditions, b									
ine	if any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause (Disease a consequence)									
Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	01).								
Medicai	d									
	IF FEMALE: 23c. If yes, outcome of pregnancy									
lan	in the past 12 months? 1 Live birth 2 Fetal death		Ectopic pregnancy				23			
Completed by Physician	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	2	Other (specify)						•	
P	Part II. Dther significant conditions contributing to death but not resulting in	n the un	deriving cause give	en in Part	1	23e. Did tob	acco us	e contribute to	the cause of death?	
by			adding and a grant	orr #11 C. C.	•		s 2			
etec									**	
dr						24a. Was ar autopsy	/	24b. Were at	topsy findings available completion of cause of	
S						perform	No X		2 🗆 No	
Be	25. Was case referred to medical examiner?		la		e of Death	Check only one	9)			
10	1 ☐ Yes 2☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou								cify)	
Ö		Time of njury	28c. Injun Work			ld. Describe ho	w injury	occurred		
cat	2 Accident investigation 3 Suicide 6 Could not be		M 1 []	Yes 2	No					
E	4 Homicide determined 28e. Place of Injury - At home, fa	If. Location (Str City or Town		Number or Ru	ural Route Number,					
ပိ										
Medical Certification:	29a. Certifier Certifying Physician: To the best of my knowledge (Check only one) Medical Exeminer: On the basis of examination and and manner state.	e, death d/or inv	occurred at the time estigation, in my or	ne, date ar pinion, dea	nd place, an ath occurred	id due to the ca	u se (s) a	and manner as place, and due	stated. to the cause(s)	
Med	and mainer stated.									
	250 Sales Signed Internal									
	D006140 01\03\06									
	30. Name and address of person who completed cause of death (Item 23a)					,				
	Dr. Charles Rudin 401 N. Broads	way	Baltimo	re, M	aryla	nd 212	:31			
tate	31. Date filed (Month, Day, Year) 32. Red Strar's Signature	,	1 10							
trar	JAN 0 4 2006 Delice 15	100	MARAGE J							

Registrar
DHMH 17 Rev 1/2001

			Please ¹	-		(Indelible Ink		-	•	le.	
		•	For Stete Registrar	State of Ma	*	epartment of I Certificate of		vientai Hy	Reg. No.	5 43785	
2	Tree Land		1. Decedent's Name (First, Middle, Las	")				2. Date of D Month		3. Time of Death	
	Physici /Medic	_	William Edward	Goo	dwin				er 29, 20		
	Examin	_	4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death	h	4c. County of	Death	
		£6.	Manor Care- Wheat	on		Silve	r Spring		Montg	omery	
	Funeral Director		578-26-9120	x 7. Age XM 2□F	e (In yrs. last birtl	hday) If Under 1 Year Months Days		8. Date of B (Month, D Sept.	irth (1925) 1925	Birthplace (State or Foreig Country) Maryland	
	pu .	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limit	
	death with the Maryland me 23a or 28e-f ehow f must be notified at	ctor	Maryland Montgo	mery	, ,	ascus				1 ☐ Yes 2 X N	
	with th	Dire	10e. Street and Number			10f. Zip Code	70		10g. Citizen of Wh	at Country?	
	ath v	B	6 Valley Park Cou			208			USA		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "natural", or iteme 23a or 28e-f ehow eny injury or other treumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☼ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 (2) Yes 2 1 If Yes, Give 1 Year or Dates:		13. Was Decedent of ff Yes, specify Cut 1 ☐ Yes 2 (3) No		pecify Yes or No Rican, etc.)		American Indian, White, etc. White	
5-0	72 ho	eted	15. Decedent's Ed (Specify only highest grad	ucation		Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	ipation o during most of wor	rkina	16b. Kind of Busi	ness/Industry	
21215-0036	vithin ne. hen	Completed	Elementary/Secondary (0-12)	Colfege (1-4or 5	1+)			•	Dogto	1 Service	
2	led v lygie her t	ပိ	17. Father's Name (First, Middle, Last)			Letter Car	-	mo (Eirot Middl	e. Maiden Sumame	1 Service	
auc	od of	Be C	Harry I. Goodwin						le Fowler		
Maryland	Shoute nd Me mark mark	2	19a. Informant's Name/Relationship (7		19b.	Maifing Address (Stree				ate, Zip Code)	
M	od 2 ilih ar 11h ar 27 le		Ruby Karen Goodw	in/ Wife	11	.520 Villa	Grand, Ft	. Myers	, FL 3391	3	
ē,	E E E		20a. Method of Disposition			Date 20c Location - City or Town State					
JO L			1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify			y, crematory or other pla on National C		n. 12, 2006	Arlington, Virginia		
Baltimore,	mit. Poartme		21. Signature of Funeral Service Licen		7 TILLINGO			Funera			
Ö	8 9 E 8		1 Cinchew	Cole		500 Unive	rsity Blv	d, W, S	ilver Spr	c ing, MD 2090	
	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or composition shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially fist conditions, if any, teading to immediate cause. Enter Underlying	Pneumo: Due to (or as b. Emphys	nia aconsequence d ema	of):	ing, such as cardiac	c or respiratory	arrest,	Approximate Interval Between Onset and Death	
68760,	certificate be executed iding physician and ise as the burial-transit	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):									
O. Box 6	death ce e attendii id for use	Completed by Physician/Medica	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. ff yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	су	1 - 11	23d. Date Monti				
α.	that	y P	Part II. Other significant conditions of	ontributing to death b	ut not resulting in	the underlying cause g	iven in Part I.	23e. Did	I tobacco use contrib	ute to the cause of death?	
rds	requires that the seen signed by th hould be detache	ed b	Hyperlipidemia					1 🗆]Yes 2. № No 3	☐ Probably 4 ☐Unknow	
Vital Records,	e law has b	omplet						per	opsy pri formed? de	ere autopsy findings availab or to completion of cause of ath?] Yes 2 \(\subseteq No	
ta	icien: Th certificate rector, pag	BeC	25. Was case referred to medicaf				26. Place of Dea				
	0 T	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospitaf:	ent 2 ER/Out	tpatient 3 DOA	thor		sidence 6 □Other	(Specify)	
on of	g e	tion: 1	27. Manner of Death 1 Whatural 5 Pending (Month, Day Year) 28b. Time of Injury Work? 2 Accident investigation 28c. Injury af Work? M 1 Yes 2 No								
Division of	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Pface of Inj	iury - At home, fa c. (Specify)	rm, street, factory, office	9		(Street and Number own, State)	or Rural Route Number,	
	Hospit 24 hours Funera etely fille	Medical C	29a. Certifier 1 A Certifying Ph (Check only one)	ysicien: To the best niner: On the basis o and manner st	f examination and	death occurred at the door investigation, in my	time, date and place opinion, death occu	e, and due to thurred at the time	e cause(s) and man e, date and place, an	ner as stated. d due to the cause(s)	
	To the To the	Me	29b. Signature and title of certifier	000	2		nse number D58962		29d. Date signed Decem	Month, Dey, Year) ber 30, 2005	

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JAN 0 6 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shashank Patel, M.D. 2309 Shorefield Road, Wheaton, MD 20902

32. Registrar's Signature

		For State Registrar	State of Mar	ylan		artment		h and M	ental Hygie	ne nn s	43786
Physicia /Medica Examine	1	1. Decedent's Name (First, Middle, Last) FLOREN 4a. Facility Name (If not institution, give	CE	6	IM	B L L 4b. City, T	own, or Locati		2. Date of Death Month DECEMBER	2 3 / 2 d 4c. County of E	
Funeral Director		HEBREW HOME OF GREATER 5. Social Security Number 578-32-4716 Usual Residence of Decedent			last birthday		ROCKVI Year If Un Days Hou		8. Date of Birth (Month, Day, Ye 12/13/192		Birthplace (State or Foreign Country) NY
e Maryland re-f show	ctor	10a. State 10b. County MARYLAND MONTGOM		Oc. Cit	y, Town or L		CKVILL	E			10d. Inside City Limits X Yes 2 No
th with th	Funeral Director	10e. Street and Number 6105 MONTROSE ROAD	#1124			10f. Zip (208	52	10g.	Citizen of What	Country?
J30	ਨ∣	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates:	er in U	.S. 13.	Was Decede If Yes, specif			cify Yes or No- Rican, etc.)		American Indian, Vhite, etc. WHITE
within than than	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)			(Give	DO NOT use	done during n retired)	nost of workin	16b	. Kind of Busine	
be fill the defendance of the party of the p	4	17. Father's Name (First, Middle, Last) SAMUEL FISCHER			KESIA	URANT	18. Mc	other's Name E COOP	(First, Middle, Maid ERMAN		OOD
		19a. Informant's Name/Relationship (Ty LYNNE COOPER/DAUGH) 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 ☑ R	TER	c	1 FR Place of Disp semetery, cre	EAS CT osition (Name omatory or oth	NORT	H POTO		LAND 2 Location - City	0878 or Town, State
Baltimore, permit. Pages 1 a Department of Hes Important: If item any injury of page once.		4 □ Donation 5 □ Other (Specify) 21. Sign tura of Filteral Sacyica Licenso	90	KI	2		Address of Fa	cility			CH, VIRGINIA ŽLAND 20852
	Ical Examiner	23a. Pari1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CDNG	5 S	uence of):	HEA		FAIL	URE		Approximate Interval Between Onset and Death
death certific	rnysician/medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tin 9 □ Unknown	Feta	I death 3	⊒Ectopic pred □ Other (spec				23d. Date of Month	delivery Day Year
se de de de de de de de de de de de de de	2	Part II. Other significant conditions con	ntributing to death but	not res	ulting in the	underlying cau	use given in Pa	art I.	23e. Did tobacc	_	e to the cause of death? Probably 4 Unknown
The The page	Completed								24a. Was an autopsy performed 1 Yes 2 🖟	prior death	
on or VI ding Physicia h. After this cert funeral direct	ation: 10 Be	25. Was case referred to medical examiner? 1 Yes 2 No F	lospital: 1 Inpatient 28a. Date of Injury (Month, Day Y		ER/Outpatie 28b. Time of Injury	-	Other	Nursing Hom	(Check only one) e 5 Residence 8d. Describe how in		Specify)
Divis	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At ho	ome, farm, si	reet, factory,	office	2	Bf. Location (Street City or Town, St		Rural Route Number,
	Medical	29a. Certifier (Check only one) 2 ☐ Medicel Examin 29b. Signature and title of certifier	sicien: To the best of a ner: On the basis of es and manner-state	kamina	wledge, dea tion and/or in	ivestigation, i	n my opinion, o	death occurre	d at the time, date a	and place, and o	due to the cause(s)
1		30, Name and address of person who co	mpleted cause of dear	th Ottor	23a) Type	Print) HO	-	56 ROI	90 . PM	EVILI	101,2006 EMD20852
Stat Registra		31. Date filed (Month, Day, Year) JAN 0 6 20	32. Fiegistrar's	s Signa	iture	parte			- , will	,-,,,,,	1

05-8926 В \mathbb{R}

.K.S		Please Type	or Print in Black Indelible Ink. Ensure Al	Il Copies Are L	egible.	
AFEEKON	NISHA GUNRAI 1 - State Registrar	Sta	ate of Maryland / Department of Health and M Certificate of Death	Mental Hygiene	005	A MANAGEMENT
	Decedent's Name (Fig. 1)	irst, Middle, Last)		2. Date of Death	Voor	T

EE	KON NIS	SHA	GUNRAI		State of Ma	aryland / De				Mental Hy	giene	005	12707
			1 - State Registrar				Certific	ate of I	Death		Reg. No:	000	43/0/
	Physici	an	Decedent's Name (2. Date of D Month	eath Day	Yeer	3. Time of Death
	/Medic Examin	al	RAFEEKUN				4b. 0	City, Town, or	Location of Death	DEC.	31,	2005 County of Deatl	1330 P [™]
	Examin	er	4a. Facility Name (If n 8227 GRE	ENSPINE	TERRANCE			ADELPH:		,	I	PRINCE	GEORGES
	Funeral Director		5. Social Security Num 212-64-97	71	ox 7. Ag □M 2K∏F	e (In yrs. last birtho 58 Yr	Mon	nder 1 Year ths Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D) 3/22/1	nth a <i>y, Year)</i> 947	9. Birth Co. Guyi	nplace (State or Foreign untry) INA
	yland		Usual Residence of D 10a. State	Ob. County		10c. City, Town o	or Location						10d. Inside City Limits
	e Mar	Director	Maryland	Prince G	Georges	Ade1	ohi						1 ☐ Yes 21 No
	or 28	Dire	10e. Street and Numb				101	. Zip Code			10g. Citiz	en of What Co	untry?
	123e	rai	8227 Gree	nspire T				20783			US	A	
	er de	Funeral	11. Marital Status		12. Was Decedent Amed Forces?		13. Was D If Yes,	ecedent of H specify Cuba	ispanic Origin? (S an, Mexican, Puert	pecify Yes or N o Rican, etc.)	0- 1	 Race - Ame Black, White 	
036	hours efter death with the Maryland turel', or Items 23e or 28e-f ehow at Examinet must be nutified at	þ	1 Never Married 3 Widowed 4	- 20	1 ☐ Yes 2 ☐x If Yes, Give Year or Dates:	No	1 🗆 Ye	s 2 XNo	Specify:			Specify: Wes	st Indian
21215-0036	2 2 2	Completed	(Specify	5. Decedent's Ed	de completed)	(9	ecedent's Give kind o	Usual Occup	ation during most of wor	king	16b, Kin	d of Business/l	industry
12	within then then	mc	Elementary/Second	lary (0-12)	College (1-4or 5	o+)		ent Of			Mor	tgage	
9	filed Hygi other		17. Father's Name (Fi	irst, Middle, Last)	-	, bc	CICII	CHC OI	18. Mother's Nan	ne (First, Middle			-
<u>a</u>	Mental Mental arked c	To Be	Mohamed	Kamalude	en				Zaitun	Bacchu	s		
Maryland	2 shoul and Me le mari		19a. Informant's Nam				_		and Number or Ru				,
	1 and 2 Health tem 27		Alana C. Gunraj M.D./Daughter 5500 Friendship Blv On Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) The Donation 5 Other (Specify)							Date Date	,	ation - City or	
Baltimore,	Pages Tient of ant: If i		1 ☑ Burial 2 🗍			cemetery,	crematory incol	or other place n Ceme	tery 1/3			ntwood,	
Ball	permit. Pag Depertment Important: eny injury o		21. Signature of Fund	oral Service Licen	Wober	9				nes-Rin			Home ng MD 20904
	Physician /Medical Examiner	er	Immediate Cause (Fi disease or condition resulting in death) Sequentially list conditions (Factor Leading to immediate Cause (Factor Leading to immediate Cause (Factor Leading to immediate Cause (Factor Leading to immediate Cause (Factor Leading to Immediate (Factor Leading to Immediate (Factor Leading to Immediate (Factor Leading to Immediate (Factor Leading to	failure. List only on al	a. Juston ach li	tisterel a consequence of	Hours Ju					sclu	Approximate Interval Between Onset and Death
,0928	cate be executed physicien and the burial-transit	ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):											
.O. Box 6	The law requires that the deeth certifi ate hes been signed by the ettending I page 2 should be deteched for use ase	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 3 Ectopic pregnancy 23d. Date of death 5 Other (specify) Month										very Day Year
rds, P	w requires that been signed b should be dete	þ	Part II. Other signific	ant conditions of	ontributing to death b	ut not resulting in t	he underly	ing cause giv	en in Part I.		tobacco us		the cause of death?
Vital Records,	The taw requirate hes been page 2 should	Completed								24a. Wa auto pen 1 Yes		24b. Were au prior to death?	topsy findings available completion of cause of
ita	icien; Th certificate rector, pag	25. Was case referred to medical examiner? 26. Place of Death (C											
<u>و</u> <	¥ 5 5	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Resider								idence 6	Dother (Spec	AT SCENE	
ion o	ding After funer	27. Manner of Death 1 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Accident investigation 1 Yes 2 No							28d. Describe	how injury	occurred		
Division	of or Attendial after death. I Director: A in by the fu	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Inj building, et	ury - At home, farm c. (Specify)	n, street, fa	ctory, office			(Street and own, State)	Number or Ru	ral Route Number,
	Hospite 4 hours Funeral ely fillec	edical C	29a. Certifier 1 (Check only 2 one)	☐ Certifying Ph Меdical Exam	ysician: To the best niner: On the basis o and manner st	f examination and/	death occu or investig	rred at the tination, in my o	ne, date and place pinion, death occu	, and due to the rred at the time	cause(s) a , date and p	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	29b. Signature and title of certifier 29c. License number								29d. Date signed (Month, Day, Year)			

JAN 06

O.C.M.E

2006

Registrar's Signature

m 23a) (Type, Print) PENN STREET, BALTIMORE, MARYLAND 21201

State Registrar

THE DONE M. KIN 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

JAN. 1, 2006

			1 - State Registrar	State of Maryland / D	epartme Certifica				Reg	ene 0 0 t	5 43788	
A.	Physici /Medic		1. Decedent's Name (First, Middle, Last) CARROLL W.	HUNT				, N	Date of Death Month	Day 200		
-	Examin		4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center			4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel		
*	Funeral Director		5. Social Security Number 2/8 - 26 - 56/3 Usual Residence of Decedent	nday) If Un	If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Country					Birthplace (State or Foreign Country) aryland		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other treumatic event, the Mudical Exp. innermatic be inclined at once.	Funeral Director	10a. State 10b. County Maryland Anne Aru 10e. Street and Number 907 Old County R		rna P	Zip Code		iin? (Specify		. Citizen of What USA	10d. Inside City Limits 1 ☐ Yes 2 ☐ No Country?	
		þ	1 Never Married 2 Marned 3 Widowed 4 Divorced	Armed Forces? 1 N Yes 2 □ No If Yes, Give Year or Dates: 1951-53	1 🗆 Yes	XXNo	Specify:	in? (Specify Puerto Ricar	n, etc.)		/hite, etc.	
		Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	completed) (Decedent's U (Give kind of life. DO NO Bus	work done a	lu <i>ring m</i> ost)	of working		b. Kind of Busine Joseph Bus Co.	Smith	
		To Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isaiah M. Hunt Marie F. Johnson									
			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Hunt(Wife) 907 01d County Rd. Severna Park, Md. 21146 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State)									
			1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) A □ Donation 5 □ Other (Specify) **Cemetery, ciematory or other place) Maryland Veteran 1-9-2006 Crpwnsville, Md.									
ă			Jarry B. Reese Mcc483 Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401									
8. 1/3 2.	Physician /Medical		Immediate Cause (Final Onset and I						Approximate Interval Between Onset and Death			
rds, P.O. Box 68760,	that the death certificate be executed by the attending physician and detached for use as the burial-transit	ation: To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Ischemic Cardiomyopathy Coronary Artery Disease >>5yrs Due to (or as a consequence of): Coronary Artery Disease >>5yrs Due to (or as a consequence of):							73 years 75 yrs		
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)						23d. Date of Month	delivery Day Year	
	w requires that been signed b should be dete		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End Stage renal Disease:						23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown			
al Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeria Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		Diabetes Mellitus									
Division of Vital			25. Was case referred to medical examiner? 1									
			2 ☐ Accident investigation	28a. Date of Injury 28b. Tir				28d. I	28d. Describe how injury occurred			
Divis		Certification:	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 29a. Certifier 29a. Certifier 29b. Modified Physician: To the best of my knowledge, death occurred at the time, date and place						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	ne Hosy n 24 ho ne Fund bletely f	Medical	29a. Certifier 1/△ Certifying Physic (Check only one) 2 Medical Examine	 iian: To the best of my knowledge, r: On the basis of examination and/ and manner stated. 	death occurr or investigati	ed at the tim on, in my op	e, date and inion, death	place, and d n occurred at	ue to the caus the time, date	e(s) and manner and place, and o	as stated. due to the cause(s)	
	To ti To ti comp	¥	29b. Signature and title of certifier							Date signed (Month, Day, Year)		
7			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNE ARUN, DEL MEDICAL CENTER									
100	9 3 -0		0 - 0	JUTCHINSON a 32. Regisfrar's Signature		Mea	lical	Par	Kway	Annas	polis Mo	
\$ 500 mg	Sta Registr		JAN 0 5 2006	A Service A Serv	Good .	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 23a per me 854 4-12-06 yt.
State of Maryland / Bepartment of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Year CHRTTS IRVIN HOWARD DECEMBER 10:20 A^M 31 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5143 CLACTON AVENUE PRINCE GEORGE'S SUITLAND If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 12XM 2□ F 52 Yrs. Director 579-70-5857 May 19 1953 NORTH CAROLINA Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show The Medical Examiner must be notified at 1X Yes 2 No Director MD PRINCE GEORGE'S SUITLAND 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or itema 23a 5143 CLACTON AVENUE 20746 U.S.A. deeth 1 Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status e filed within 72 hours after dail Hygiene.
other than "natural", or item Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2X No Specify. δ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th WINDOW WASHER PRIVATE permit. Pages 1 and 2 should be filed Department of Heelth and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, IL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RAYMOND HOWARD ELSIE MAE JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1712 SHAMROCK AVENUE CAPITOL HEIGHTS, MARYLAND 20743 LUJUAN HOWARD/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY 1/7/2006 SUITLAND, MARYLAND 21. Signature of Funeral Service 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Approximate Interval Between Onset and Death cations that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Finat **Physician** ATHEROSCLEROTIC CARDIOVASCULAR HEART DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine signed by the attending physicien and deed detached for use as the burial-transit CERTIFICATION APPROVED BY MEDICAL EXAMINER requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2CXNo 2 No 1 TYAS 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Z Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 XYes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 XNatural 5 Pending death. investigation 1 Tyes 2 No 2 Accident after death Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitai within 24 hours a To the Funerai D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical The Certifying Physician: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Loco OCEN 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hos 31. Date filed (Month, Day, Year) . Registrar's Signature State JAN 05 2006 Registrar

AEM 05-08931 Charles No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

les	Norve		Hendricks	State of Ma		id / Depa	artment	of He	ealth ar	•		ene no c	10700
			1 - State Registrar			Cei	rtificate	of D	Peath			g. No. UUJ	43/90
	Physici	an	Decedent's Name (First, Middle,							2. Date Mon	of Death	n Day Year	
	/Medic Examin	ai	Charles Norvill 4a. Fecility Name (If not institution,	e Hendrick give street and number)	s		4b. City, To	own, or l	Location of		ember	31, 2005 4c. County of De	
	LAdinii		201 Cherry Hill				_	ure				Anne Ar	
	Funeral		5. Social Security Number 6			last birthday)	If Under 1		If Under 24		of Birth		rthplace (State or Foreign country)
	Director		378-36-3208 Usual Residence of Decedent	122 W 201	_67	Yrs.				Oct	. 30	, 1938 Mic	higan
	yland 10W		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	e war	ctor	Maryland Anne Ar	undel	Lau	rel							1 ☐ Yes 2X No
	or 28	Dire	10e. Street and Number				10f. Zip C				10	g. Citizen of What C	ountry?
1	238	erai	201 Cherryhill L		Come in 11	6 112	2072		0.1.1	0.00		.S.A.	
	T I I	by Funeral Director	11. Marital Status 1 □ Never Married 2 X Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 🗓 N						n? (Specify Yes Puerto Rican, e	tc.)	14. Race - Arr Black, Wh	
9	Figure 9	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 □ Yes 2	No	Specify:			Specify:	White
21215-0036	within 72 nouts eller deem with the maryland ene. 9ne. 1 then *neturel; or iteme 23a or 28e-f ehow the Madical Examiner must be notified at	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	dent's Usual kind of work DO NOT use	Occupat done du	tion uring most o	of working	1	6b. Kind of Busines	s/Industry
12	then then	dui	Elementary/Secondary (0-12)	College (1-4or 5	i+)						,	TOD A	
g 5	Hygin other	e Co	17. Father's Name (First, Middle, La	st)		мапад	ement			s Name (First, I		JSDA laiden Sumame)	
an i	Mental Mental	To Be	Norville Hendric	ks]	Pearl	Wright			
Maryland	and h		19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street ar	nd Number	or Rural Route	Number,	City or Town, State,	Zip Code)
≥ ' 6	lealth Im 27 her tr		Janice M. Hendri	cks - Wife	205 5				Lane		1000	aryland 20	
Baltimore,	permit. Pages 1 end 2 should be little waryland. Pages 1 end 2 should be little waryland. Pages 1 end 2 should Mental Hygiene. Interportant: if item 27 is marked other then *neturel; or iteme 23a or 28e-f show eny injury or other treumatic event, the Madical Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		0	Place of Dispo semetery, crer	natory or oth	er place		Date		0c. Location - City o	
	ortani Injury		4 □ Donation 5 □ Other (Spe 21. Sign ture of Funeral Sepvice Lic	7 **	For	t Line	oln Ce	eme t	ery 0	1/06/20	06 B	rentwood, neral Home	Maryland
ã	Depe Impo		Men & Ye	bul.									e, MD 20781
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	implications that caused by one cause on each lir	the deat	h. Do not ent							Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition	a. Contact Due to (or as	t qui	ashot w	t Owo	0 h	20				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):							
		er	Sequentially list conditions,	b. Due to (or te	a nansaq	uarina of)-							
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
760,	ate be executed hysiclan and the burial-transit	Exe	resulting in death) Last	Due to (or as	a conseq	uence of):							
on •	cate property of the bu	dical		d									
9 ×	ding I	by Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregna	ancy						and Date of the	
m į	e etter d for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Feta	Ideath 3	Ectopic pred Other (spec					23d. Date of de Month	Day Year
0	by the	hys	9 Unknown	9□ Unknown									
Ś.	w requires that the death certifical been signed by the ettending phishould be detached for use as the		Part II. Other significant conditions	contributing to death but	ut not res	ulting in the u	nderlying cau	ise giver	n in Part I.	23e		1	to the cause of death?
oro	neen s	eted								-	1 🔲 Yes		robably 4 Unknown
Division of Vital Records, P.O. Box 6	Authoring Frigstoan. The law requires that the bearn centino docation. After this certificate hes been signed by the ettending ph by the funeral director, page 2 should be detached for use as the	Completed		-						24a	. Was an autopsy perform	prior to	utopsy findings available completion of cause of
国	tificate tor, pa	0	25. Was case referred to medical		-				26 Place of	1 Death Check	Yes 2	□ No 15 X	s 2 No
)	is cer direct	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	nt 2 🗆	ER/Outpatier	it 3□ DOA	Other				nce 6 Stoyt her <i>(Sp.</i>	ecity) Scene
0 2	fter th		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injur (Month, Day	y Year)	28b. Time of	280	. Injury a			cribe hov	v injury occurred	
Sio	tor: A	icati	2 ☐ Accident investigat 3 ☑ Suicide 6 ☐ Could no	ha - 1, 2003		5:47	PM	1 🗆 Y	es 200 No		a	ed shot	
	after after Direct	Certification:	4 Homicide determine	28e. Place of Inju- building, etc	S. (Specif	ome, farm, str		office		City	or Town,		
_	papire hours ineral y filled		29a. Certifier 1 Certifying	Physician: To the best of	of my kno	wiedge, death	n occurred at	the time	a, date and	place, and due	to the car	J HTL Ln, L	s stated
	of the property of Attending Priyacters. The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2.	edicai	(Check only 2 Medical Ex	aminer: On the basis of and manner sta	examina	tion and/or in	vestigation, in	n my opi	nion, death	occurred at the	time, dat	te and place, and du	e to the cause(s)
	Tot	Σ	29b. Signature and title of certifier	4	1 .		29c.	License	number		29	d. Date signed (Mon	th, Dey, Year)
Λ	(1)		John S	Feel	No	>		OCME				January 1	L, 2006
1-	(12)		30. Name and address of person who Tuska ZGV earbers 7.0	no completed cacse of de 111 Penn S	eath (Iten Stree	n 23a) (Type. et, Bal	Print) Lt i more	e, M	ary1a:	nd 2120	1		
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 5 200	S Registra	ar's Signa	ture	e e						
-						-							

			1 - For State RegistraMEND#1perM		Ò	Cer	tificate o	f Death		Reg. No.	105	43791
	Physici		Decedent's Name (First, Middle	Xiao Die I	Huang	(AKA)	Judy H	lyang	2. Date of D Month	Day	Year 2.005	3. Time of Death
	/Medio Examin	41	4a. Facility Name (If not institution	give street and number)			4b. City, Town	, or Location of De			unty of Death	(102)
		<u>\$</u>	Montgomery Ge				01ne			Мо	ntgome	ry
	Funeral Director		5. Social Security Number 228.41.3080	1 □ M 2187 E	e (In yrs. Ia 50	St birthday) Yrs.	If Under 1 Yes Months Day			lav. Year)	Cou	* /
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation					10d. Inside City Limits
	Mary	tor	Maryland Mont	gomery	Si	lver S	pring					1 ∑Yes 2 □ No
	th the	Directo	10e. Street and Number				10f. Zip Code)		10g. Citizen	of What Cour	ntry?
	ath wi	ral	2022 Seattle A	Avenue			20905	j		U.S	.A.	
5-0036	172 hours after death with the Maryland "natural; or frems 23a or 28e-f ehow refical Examinal must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Marr 3 □ Widowed 4 □ Divorced	12. Was Decedent If Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:		If	/as Decedent o Yes, specify Co ☐ Yes 2 1 N	f Hispanic Origin? uban, Mexican, Pud lo Specify:	(Specify Yes or Nerto Rican, etc.)		Race - Americ Black, White, ecify: Asi	etc.
21	within 72 ho ene. than "natur he Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)		+)	(Give) life. D	O NOT use reti	ne during most of w	t &		of Business/In	dustry
N	Hyg ther nt.		17. Father's Name (First, Middle,			CIII	nese op		ame (First, Middle	Musi a. Maidan Sur		
_	bed la be	To Be	Zheng Qin	Huang	915			Chang		Wu	====	
-	0.00		19a. Informant's Name/Relations					et and Number or				
	1 and 1 and		Chu Shan Zhu 20a. Method of Disposition	/Husband	20h Pla		Seattle Sition (Name of	Avenue,	Silver		, Mary	land 20905
altimore,			1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		СӨІ	metery, crem	atory or other p	eme. 12/2			,	
붍	permit. Pages Deportment of Important: If it any nigney of once		21. Signature of Funeral Service		Gate			ress of Facility ALDI FUNI				g,Maryland
m	Thysician /Medical	22 13	23a. Part1. Enter the distase, or shock, or hearthfur. List Immediate Cause (Final disease or condition resulting in death)	a. Metar	10/12	Do not ente	SUU New or the mode of d	Hampshi	re Ave, S	Silver	Spring	Approximate Interval Between Onset and Death Lemonths
-42	Examiner			Due to (or as	a conseque	ence of):						
	pg is	iner	Sequentially list conditions, if any, reading to infine date cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as	a sunsuque	rice of):						
	icate be executed physicien and s the burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as	a conseque	ance of);						
68760	e be e	edical E		d								
Ψ		ledi	1222									
.О. Вох	at the death certifi by the attending tached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal o	leath 3 🗌	Ectopic pregnar Other (specify)			23d.	Date of delive Month	ery Day Year
rds, P	as this gned se de	by	Part II. Other significant condition	ns contributing to death bu	ut not result	ting in the un	derlying cause	given in Part I.		tobacco use o		ne cause of death?
Records,	e law requir has been si ie 2 should t	Completed							24a. Was	opsy	prior to cor	psy findings available mpletion of cause of
									1 ☐ Yes	ormed?	death?	2KNo
Vital	sicia: certil	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	-1 005	D/Out-the	2000	Nh	eath Check only			
Division of	To the Hospitel or Attending Physician: whith 24 hours after death. To the Funeral Director. After this certification and the funeral director. completely filled in by the funeral director.	P- 9	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig		ry 2	R/Outpatient 28b. Time of Injury	28c. In	4 Nursing	Home 5 Res			y)
Divis	s after des s after des ni Directo ed in by th	Certification;	3 Suicide 6 Could r 4 Homicide determ	28e. Place of Inju	ury - At hon c. (Specify)	ne, farm, stre	et, factory, offic	e		(Street and Ni own, State)	umber or Rura	l Route Number,
	the Hospi in 24 hou the Funer pletely fill	edicai	29a. Certifier (Check only one) Certifyin Certifyin Certifyin	g Physician: To the best of Examiner: On the basis of and manner sta	examination	ledge, death on and/or inv	occurred at the estigation, in m	time, date and pla y opinion, death oc	ce, and due to the curred at the time	cause(s) and , date and pla	d manner as st ce, and due to	tated. o the cause(s)
	with To t	Σ	29b. Signature and title of certifier					nse number		29d. Date sig	gned (Month,	Day, Year)
•	6		Paulbanum	мр				60335		Decem	ber 2	3, 2005
			30. Name and address of person		eath (Item :	23a) (Type, F	Print)	327 0	_1 -	. 0	. 00.	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 06	18111 Prince 2006 Registra	ar's Signatu	ire Ange	AL THE	5-7	DI nay, A	10 2	-0 032	aller.

			For State Registrar	State of Mary	land / Depa			lental Hygi	•	05	43792
15	Physici		Decedent's Name (First, Middle, Last)					Date of Death Month	Day	Vear	3. Time of Death
n duisi	/Medic		Milton Eugene Ha	arris				December	25,	2005	5:42 P M
	Examir	er	4a. Facility Name (If not institution, give s				r Location of Death		4c. Cour	nty of Death	
		S. San	Washington Advent			Takoma			Mor	tgome:	
277	Funeral		5. Social Security Number 6. Sex	7. Age (In M 2□ F 95	yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Dec • 4,	(ear)	9. Birthp	place (State or Foreign
460	Director		549-36-4675 Usual Residence of Decedent	95	113.			Dec. 4,	1910	wash	ington, DC
	land ow		10a. State 10b. County	100	c. City, Town or Lo	cation				1	0d. Inside City Limits
	Man Feb	ţō	D.C. N/A	,	Washingto	on					1 ∰Yes 2 ☐ No
	r 28e	irec	10e. Street and Number			10f. Zip Code		100	J. Citizen o	of What Cour	ntry?
	th wit	aiD	1121 Allison Stre	eet, N.W.		20011			Unite	d Stat	tes
	within 72 hours after death with the Maryland ene. Than "natural", or Items 23e or 28e-f ehow he Madical Exeminer must be notified at	by Funeral Director	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13. \	Vas Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto		14. R	ace - Americ	an Indian,
9	or its	/Fu	1 ☐ Never Married 2 ☐ Married	1 XYes 2 No	1777	Tes, specily Cubi	Specify:	nican, etc.)		lack, White,	etc.
93	ural',	d b	3 XWidowed 4 □ Divorced	Year or Dates:	1945	103 212110	Specily.		Afr	ican A	American
21215-0036	"nati	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	lent's Usual Occup kind of work done	during most of work	ng 16	3b. Kind of	Business/Ind	dustry
12	withir sne.	du	Elementary/Secondary (0-12)	College (1-4or 5+)	_	00 NOT use retired erer	a)		Food	Servi	
2	Hygid ther int,		17. Father's Name (First, Middle, Last)	<u>+</u>	Cate	-161	18. Mother's Name				ie
an	d be antal	To Be	Harry Harris				Marie Be			207	
Maryland	Shoul od Me mark	ř	19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Mailir	a Address (Street	and Number or Rura		City or Tow	m State Zin	Codel
N	od 2 Ith ar 27 Is r trau		Jacqueline H. Leon							19122	3000)
<u>6</u>	t Head the other		20a. Method of Disposition		Ob. Place of Dispo					n - City or To	wn, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hydiene. Depertment of Health and Mental Hydiene. Important: If item 27 is marked other than "natural; or items 23s or 28e-f show important: If item 27 is marked other than "natural; or items 23s or 28e-f show important; items 23s or 28e-f show important; items 23s or 28e-f show into items 23s or 28e-f show items 23s or		1 ⊠ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Ft. Linco			′06 В	rentw	ood, N	Maryland
alti	mit. Sertm Sorts		21. Signature of Funeral Service License	90	22	. Name and Addre	ss of Facility McG			-	
Ö	Depending on it		Undre The	verson !			gia Ave.				20012
	Physician /Medical Examiner popular-transit	Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	adi	1	vnaey	aue	st			Interval Between Onset and Death
8760,	ate be hysicie the bur	cai	€ a	i							
.O. Box 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and ral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy	/			Date of delive	ory Day Year
σ,	s tha	y P	Part II. Other significant conditions con	tributing to death but no	t resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use co	ntribute to th	ne cause of death?
Records,	w require been sig should b	eq	mo suy	Unal	auxa	on on	dialips	1 🗆 Yes	2 X No	3 🗆 Prob	ably 4 Unknown
900	aw re as be 2 sho	piel						24a. Was an	241	o. Were autor	psy findings available
Ä	The ate ha	mo;						autopsy performe	d? ₹No	death?	npletion of cause of
ita	ian: rrtifica ctor,	Bec	25. Was case referred to medical examiner?				26. Place of Death		2110		
>	nysic nis ce I dire	10	1 ☐ Yes 2 📉 No	ospital: 1 🔀 Inpatient	2 ER/Outpatien	t 3 DOA Oth	er: 4 Nursing Ho	me 5 Residen	ce 6 □C	ther (Specify	()
0	De te		27. Manner of Death 1 ↑ Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time of Injury	28c. injur Wor	y at k?	28d. Describe how	injury occ	urred	
sio	Attending r death. ctor: Atter by the funer	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No				
Division of Vital	al or Attendi after death. I Director: A d in by the fu	ertifi	4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str pecify)	eet, factory, office		28f. Location (Stre City or Town,	et and Nur State)	nber or Rura	l Route Number,
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: Af	Medical Certification:	29a. Certifier 1⊠ Certifying Phys (Check only 2 Medical Examin	sician: To the best of my ner: On the basis of exa and manner stated.	y knowledge, death mination and/or in:	n occurred at the tir vestigation, in my o	ne, date and place, pinion, death occurr	and due to the cau ed at the time, date	se(s) and reactions	manner as st	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. Licens	e number	290	. Date sign	ned (Month, i	Day, Year)
)	12+1		· Mu			5	6147		12/2	29/0	r.
	1 -		30. Name and address of person who co						1		
		Į	Nasreen Kango, M			Ave., Ta	koma Park	, MD 20	912		
	Stá Registi		31. Date filed (Month, Day, Year) JAN 0 5 20	32 Registrar's S	Signature	in the					

			1 - For Amend #5&7 Pe		123/07 P	annent ortificate	of Health and of Death	Reg.	ne 2005	43793
	Physici	ian	Decedent's Name (First, Middle, Las					Date of Death Month	Day Year	3. Time of Death
	/Medi		Raymond Alexande						31, 2005	9:45 P M
1 *	Examir	ner	4a. Facility Name (If not institution, give				wn, or Location of Dea	ith	4c. County of Dea	
nide:	gill hely		Genesis Eldercare 5. Social Security 2088 6. Se		nter last birthday)	If Under 1	Annapolis Year If Under 24 Hr	S 9 Date of Birth	Anne Ar	
	Funeral Director			M 2□F 9			Days Hours Mir			thplace (State or Foreign cuntry) ennsylvania
	Maryland -f show fied at	tor	10a. State 10b. County Maryland Anne A		City, Town or Lo	ocation	Annapol	is		10d. fnside City Limits 1 ☐Yes 2 ☐ No
	ours after death with the Marylar rai', or items 23a or 28a-f show Esacht af mast be notified at	Il Director	10e. Street and Number 1205 Tyler Avenue	9		10f. Zip Co	-		Citizen of What Co	•
	death ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Deceden	t of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Ame	erican Indian,
5-0036	72 hours after death with the Maryland Insturel, or items 23s or 28s-f show Licel Exacting must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ፟፟ ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: ₩₩	II	1 Yes, specify		rto Hican, etc.)	Specify: W	e, etc. hite
21215-0		Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual C kind of work o DO NOT use i	done during most of we	orking 16t	. Kind of Business	/Industry
2	filed withi Hygiene. other than		12			Electr			J.S. Gove	rnment
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than sumatic event, tre Ms	To Be	17. Father's Name (First, Middle, Last) Alexander Henk					Johnson	den Sumame)	
	1 and 2 shi Health and Iom 27 is m		19a. Informant's Name/Relationship (T Wayne R. Henk/so	•		15777		Annamlis Annamlis		
Baltimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 ② Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	Place of Dispo cemetery, cres Ltimore	natory or othe	of r place)	Date 200	. Location - City or	Town, State
Baltii	permit. Pag Department Important: I any injury o		21. Signatur Uneral Coe Licent	tille	22	. Name and A	Address of Facility Jo	ohn M. Tayl ster St., A	or Funera	Maryland al Home MD 21401
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	lications that caused the deane cause on each line. a	P	er the mode o		ic or respiratory arrest,		Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and nd for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect. Due to (or as a consect.)						
.O. Box 6	t the death certific by the attending pi tached for use as it	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pregr Other (speci			23d. Date of del Month	ivery Day Year
rds, P	w requires that been signed should be dei	þ	Part If. Other significant conditions co	ntributing to death but not re	sulfing in the u	nderlying caus	e given in Part I.	23e. Did tobacc	1-	the cause of death?
of Vital Records,	e la has je 2	Completed						24a. Was an autopsy performed 1 Yes 2	? prior to death?	topsy findings available completion of cause of
ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place of De	ath (Check only one)	10 103	20,140
\	S 5	10	1 Yes 2 Do	Hospital: 1 ☐ Inpatient 2 ☐]ER/Outpatien	t 3 DOA	Other: 4 Nursing	Home 5 Residence	6 ☐Other (Spec	cify)
	ding After fune		27. Manner of Death 1 Separatural 5 Pending 2 Accident investigation	28a. Date of Injury . (Month, Day Year)	28b. Time of Injury	28c.	Injury af Work? 1 □ Yes 2 □ No	28d. Describe how it	njury occurred	
Division	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, str ify)	eet, factory, of	fice	28f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
	in 24 hou he Funer pletely fill	Medical	29a. Certifier (Check only one) Certifying Phy 2 Medical Example (Check only one)	sicien: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the control of the contr	he time, date and plac my opinion, death occ	e, and due to the cause urred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of codifie	ww		4	cense number		Date signed (Month	
_			Gay & Sov	ompleted cause of death (fte	m 23a) (Type,	Print)	nous (6 /1 Lester M.	2/6/9	
	Sta		31. Date filed (Month, Day, Year)	32 degistrar's Sign	at A	alle				

			For Amend Item State Registrar	tate of Maryland	G853, Cei	03/15/06 tificate of	lealth and Death	Mental Hy	giene () () Reg. No.	5 43794
	Physicia	an	1. Decedent's Name (First, Middle, Last)	Hunbes	Sr			2. Date of De Month	eath Day Y	3. Time of Death 905 4:40PM
	/Medic Examin	2,000	4a. Facility Name (If not institution, give stre 406 Bridge St	et and number)		4b. City, Town, o	r Location of Dea		4c. County of	
	Funeral Director		221-18-7160	7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr. Hours Min		ay, Year)). Birthplace (State or Foreign Country) Maryland
	Aaryland f ahow	or	Usual Residence of Decedent 10a. State 10b. County Delaware Sussex		Town or Lo					10d. Inside City Limits 1 ☐ Yes 2X No
	or 28a-	Director	10e. Street and Number		calor	10f. Zip Code			10g. Citizen of Wh	at Country?
	ath wi	ral	26822 Walker Road	W 8 4 3 6 3 1 1 1 6	140	1997		Carati Van as N	USA	American Indian,
036	d within 72 hours after death with the Maryland glene. Than "natural", or Itama 23a or 28a-f ahow The Madical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes ※☐ No	Specify:	rto Rican, etc.)	Black, Specify:	White, etc. white
21215-0036	within 72 ho ene. than "naturi he Medical I	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)		(Give life	dent's Usual Dccup kind of work done DO NOT use retired CK Driver	during most of w d)	orking	16b. Kind of Busin	
and 21	be filed tal Hygi d other event, I	Be	12 17. Father's Name (First, Middle, Last) Ira Martin Hughes	_	ILU	CK DLIVE	18. Mother's Na	May Benn	, Maiden Sumame)	Trucking
Maryland	s 1 and 2 should be t Health and Mental fem 27 is marked o other traumatic ave	T ₀	19a. Informant's Name/Relationship (Type, Nellie Mae Hughes/w			ng Address (Street 22 Walker			per, City or Town, St	ate, Zip Code)
	ages 1 and 3 nt of Health t: If Item 27 y or other try		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Rem	20b. Pl	ace of Dispo metery, crer	sition (Name of natory or other pla	ce)	Date 4/06	20c. Location - C	,
Baltimore,	permit. Pages 'Department of H Important: If Ite any injury or ot		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		dens 22	Name and Addre	ss of Facility Funeral	Home Pro	Hebron ofessiona oury, MD	l Association
	Physician		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one disease or condition	tions that caused the death cause on each line.	. Do not ent	er the mode of dyi	ng, such as cardi	ac or respiratory a	ırrest,	Approximate Interval Between Onset and Death
M.	/Medical Examiner		resulting in death)	NON - Ho	ence of):	LINS	Lyn	PHOR	CINOMI 1A.	
8760,	ate be executed thysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ						
.O. Box 687	death certific e attending p od for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregnal 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnanc	y		23d. Date Monti	
o, O	luires that i signed by ild be deta	þ	Part II. Other significant conditions contri	buting to death but not resu	Ilting in the u	nderlying cause gr	ven in Part I.			ute to the cause of death?
of Vital Record	The law requires that the rate has been signed by the page 2 should be detache	Completed						24a. Wa auto perf 1 🗆 Yes	opsy pri- ormed? de	ere autopsy findings available or to completion of cause of ath? I Yes 2 ()
	g Physician: The er this certificate eral director, pag	n: To Be	27. Manner of Death	pital: 1 Inpatient 2 1 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	II 3L DOA	ner: 4 □ Nursing		one) Idence 6 O Other how injury occurred	
Division	To the Hospitel or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	1 Selatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, st	M 1	Yes 2 □No		(Street and Number own, State)	or Rural Route Number,
۵	To the Hospitel of within 24 hours af To the Funeral D completely filled in	Medical Cer		ian: To the best of my knors: On the basis of examinal and manner stated.						
	ro the vithin 2 ro the comple	Mec	29b. Signature and title of certifier	and mainer stated.		29c. Licen	se number		29d. Date signed (Month, Day, Year)
	C	1	> 8C	plated cause of death (Item	23a) /T::::-		58411		1/3/00	
300	100		30. Name and address of person who come	Lis 2621	66 A	HP E	WOOD	CT- S	HLISBL	iRy wo 2/20
100	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	L A					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year December 23, 2005 6:25 A. Theodore R. Jenkins /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Thomas More Nursing & Rehabilitation Canter Prince George's Hyattsville 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1√2 M 2 □ F 40 579-82-6639 Director March 1, 1965 Washington, D.C. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Prince George's Glenarden Maryland Yes 2 No Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 1513 7th Street 20706 U.S.A. or items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. is 1 and 2 should be filed within 72 hours after of thealth and Mental Hygiene.
Ifem 27 is marked other than "natural", or iter
other fraumatic event, the Medical Examinate 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Janitorial Engineer Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charlie Jenkins Earnestine Gerald 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State. Zip Code) 1513 7th Street Glenarden, Maryland 20706 19a. Informant's Name/Relationship (Type, Print) Mrs. Sabrina Nicholas-Jenkins (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H important: if ite any injury or otl ance. 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Chesapeake Crematory, Inc. January 5, 2006 Beltsville, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rollins Funeral Home, Inc. ulmer 4339 Hunt Place, N.E. Washington, D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Human Immunodeficiency Virus/AIDS Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine ed by the attending physicien and detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 requires that the death certificate be Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown page 2 should be detach Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 21X No 2X No 1 Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier 🄁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D01852 January 5, 2006 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul A. Devore, MD 4203 Queensbury Road Hyattsville, Maryland 20781 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JAN 0 6 2006 Registrar

	_	For State Registrar	State of Maryland / Dep		Mental Hygien	2005 4	3796
Physicia /Medic Examin	an al	Decedent's Name (First, Middle, Last) Raymond Walter 4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Deat	December 3	31, 2005 1: c. County of Deeth	Time of Death
Funeral Director				Centreville If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth		State or Foreign
death with the Maryland ma 23s or 28s-f show crost be netitied at	ector	Usual Residence of Decedent 10a. State 10b. County MD Caroline 10e. Street and Number	10c. City, Town or L Greenst		100.6		side City Limits
ath with t	Funeral Director	112 South Main str		21639	1	Jnited State	
hours after des tural', or Items	by	11. Marital Status 1 Never Married 2 Married 3 Nover Married 2 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1. Yes 2 No 1951 TYPES, Give Year or Dates:	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes	Specify Yes or No- to Rican, etc.)	14. Race - American Inc Black, White, etc. Specify: Whit	
within 72 ene. than "nai	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+) (Giv	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired) Sheet Metel Worker	rking	Kind of Business/Industry	,
ld be file ental Hyg ked othe ic event,	To Be Co	17. Father's Name (First, Middle, Last) Louis Jenkins		Margar	me (First, Middle, Maide et Mary Erl	nart	
is 1 and 2 shou of Health and M item 27 is mar other traumat		19a. Informant's Name/Relationship (Tyr Carolyn Jenkins (c	laughter) 112 S		Box #796	Greensboro,	MD 216
permit. Pages 1 Department of H Important: If ite any injury or ott		20a. Method of Disposition 1 the Burial 2 ☐ Cremation 3 ☐ R 1 do Donation 5 ☐ Other (Specify)	Fort Line	position (Name of emalory or other place)	2006 Br	Location - City or Town, Sentwood, MD	
Depariment Depariment Depariment Depariment Depariment Department		21. Signature of Funeral Service License	3	22. Name and Address of Facility ${ t For}$	load Brenty		
Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not end end cause on each line. Majorando M Due to for as a consequence of):	nter the mode of dying, such as cardia	c or respiratory arrest,	Inter	roximate val Between et and Death
Examiner and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ing discusse		ije. Ge.	
ficate be executed physicien and s the burial-transi	Icai	L					
The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 11 Yes 2 No 9 Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day	Year
luires that signed b		Part II. Other significant conditions con			./	o use contribute to the cau 2 No 3 Probably	
The law require ate has been sig page 2 should b	Completed	Chronic obst.	rudiva pulmonon e	lisease	24a. Was an autopsy performed 1 Yes 2		ion of cause of
sicien: Th certificate irector, pag	Be	25. Was case reterred to medical examiner?	lospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	201	ath (Check only one) Home 5 Residence	6 Dother (Conside)	
To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injury (Month, Day Year) 28b. Time Injury 28b. Place of Injury - At home, farm, so building, etc. (Specify)	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	jury occurred and Number or Rural Rou	te Number,
Hospital or 24 hours afte Funeral Dir etely filled in I	Medical Ce	29a. Certifier (Check only one)	sician: To the best of my knowledge, deaner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and plac investigation, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as stated. and place, and due to the c	ause(s)
To the within 2. To the complet	Me	29b. Signature and title of certifier	600	29c. License number 72,593	3 29d. [Date signed (Month, Day,	Year)
- (3)		30. Name and address of person who co	empleted cause of death (Item 23a) (Type Whey, MD 610	Dutchmans Land	, Easton	MD 210	(0)
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	all a			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#23a,perf().0851,1/30/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** P^{M} December 29, 2005 9:55 Paul T. Kalanevich /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Crownsville 800 Hollywood Blvd. Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** 1ਊM 2□F Days 1960 Takoma Park 45 Yrs. Director September 10, 218-78-0127 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State 28a-f show other treumatic event, the Mudical Examiner must be notified at 1√2 Yes 2 □ No Crownsville Maryland Anne Arundel Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 21032 USA 800 Hollywood Blvd. Items 23a Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐Yes 2 XNo Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced natural 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private Investigator PVT. 4 Yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental F int: If item 27 is marked of Marcella Slank Thomas F. Kalanevich ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 800 Hollywood Blvd. Crownsville, MD Laura Kalanevich / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State to # 1 ☐ Burial 2 XCremation 3 ☐ Removal from State ō Department of Important: If any injury or once. Metropolitan Crematory 12-30-05 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Beall Funeral Home 21. Signature of Funeral Service Licenses 10 6512 NW Crain Hwy. Bowie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Design On It S Immediate Cause (Final disease or condition resulting in death) Enysician Liver Failure /Medical Due to (or as a consequence of): **Examiner** Zieves Syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Physician/Medical The law requires that the death certificate IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 Yes 3 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe 2 🔀 No Division of Vital Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M D21438 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Michael LaPenta 445 Defense Hwy. Annapolis, MD 21401

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 0 6 2006

. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year December 29, 2005 **Physician** 10:38 a M Maria Kennedy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 28 F 1948 Colombia 230-17-8894 57 April 27, Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. fnside City Limits 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Montgomery Silver Spring Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11501 Amherst Avenue, #201 20902 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bfack, White, etc. within 72 hours after 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 XXYes 2□No Specify: Colombian \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Special Police Officer Security 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 end 2 should be fill ment of Heelth and Mental H lant: If Item 27 is marked ott Thomas Renteria Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Thomas Kennedy/ Son Co. 16th SIG, Ft. Hood, TX 76544 20b. Place of Disposition (Name of cemetery, crematory or other place) January 12, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veteran's Cemetery 2006 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licenses 22 Name and Address of Facility Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, any in MD 20901 23a. Part1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List of tyone cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIOMYO PATHY **Physician** /Medical Examiner ATHEROSCIEROTIC CARDIOVASCALARDISESSE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed physicien and s the burial-transit resulting in death) Last Due to (or as a consequence of): .O. Box 68760, Physician/Medical use as the 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9□ Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed' 20 certificate 1 Yes 1 Tes of Vital or Attending Physicien: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Tes 2 1 Inpatient 2 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manper of ath 2 b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Accident Division 5 ☐ Pending s efter death. f Director: Aft d in by the fun 1 Yes 2 No investigation 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funerel I completely filled To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of ceptifier 29d. Date signed (Month, Day, Year) 2050545 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7513 Hampshire 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 06 2006 Registrar

			1 - State of Maryland / De State of Maryland / De	epartment of H Certificate of t		nd Menta		ene 1. No. 0	5	3799
			Decedent's Name (First, Middle, Last)			2. Date	of Death	Day	Year	3. Time of Death
	Physicia /Medic		JACK KRATCHMAN				2	27		11:33 A. ^M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	r Location of I	Death		4c. County	of Death	
			Suburban Hospital	Bethes		4 Slee	(5)	Mont	gomer	-
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Davs		Min. (Mor	of Birth	'ear)	9. Birthpla	ace (State or Foreign
	Director		Usual Residence of Decedent	-	<u> </u>	UCL	. 12,	1926	New 1	ork
	/land		10a. State 10b. County 10c. City, Town of	or Location					10	d. Inside City Limits
	Many 9-f sh	tor	Maryland Montgomery Potoma	с						1 ☐ Yes 2 ☐ No X
	th the	irec	10e. Street and Number	10f. Zip Code			100	g. Citizen of \	What Count	ry?
	23e	Funeral Director	11215 Seven Locks Road # 102	20854	<u> </u>			U.S.		
	r dea	nei		 Was Decedent of H If Yes, specify Cuba 	lispanic Origir an, Mexican, I	n? (Specify Yes Puerto Rican, e	s or No-		e - America ck, White, e	
36	hours after death with the Maryland turel', or Items 23e or 28e-f show at Examiner must be notified at	by Fi	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No Army If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates: 1,77,7 2	1 ☐ Yes 2 ☐XNo	Specify:			Specify	www.Whi	te
15-0036	72 hours after death with the Marylar "naturel", or liems 23e or 28e-f show dical Examiner must be notified at	ed b	7474 2	ecedent's Usual Occup	nation		16	Sb. Kind of B	usiness/Indu	ustrv
Ċ	filed within 72 Hygiene. other then "natent. Ine Modic	Completed	(Specify only highest grade completed)	Give kind of work done ife. DO NOT use retired	during most of	of working				
212	yiene yiene r the	шо		eologist				U.S.	Gove	rnment
פ	e file at Hyg othe vent.	Be C	17. Father's Name (First, Middle, Last)		18. Mother's	s Name (First,	Middle, Ma	uiden Suman	ne)	
<u> </u>	should be nd Mental marked c	To E	Samuel Kratchman		Dora	a Bende	r			
a	d 2 should be filed within 72 hou h and Mental Hygiene. 7 is marked other then "nature treumetic event. The Modical E		1.121	Mailing Address (Street						
≥	and ealth m 27			15 Seven Lo	ocks Ro					
Baltimore, Maryland 2121	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked eny injury or other treumetic engines.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Pemoval from State	Disposition (Name of crematory or other place		Date	100	c. Location -	•	
Ē	tent:			al Cremator			05 F	'alls (Church	, Virginia
Bal	permit. Departr Importe eny inje		21. Signature of Funeral Service Licensee	22. Name and Addre	TAL Fire	noral D	irect	ion,]	Inc.	
	20204		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	T091 Rocky	ville I	Pike, R	ockvi	11e, 1	lary la	nd 20852 Approximate
١.			shock, or heart failure. List only one cause on each line.	tomor mo mode or dyn	19, 300m as ac 1	ardias or roopin	atory arros	.,		Interval Between Onset and Death
П	Physician /Medical		disease or condition a. Cange STIVE H	eart tail	ure					
	Examiner		Due to or as a consequence of	II.						
		er	Sequentially list conditions, if any, leading to immediate b. — Due to (or as a consequence of)):	_					
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.							
o,	exec an an rial-tr	Exa	resulting in death) Last Due to (or as a consequence of)):						
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	dicai	d							
9	ntifica ing ph e as ti	a	IF FEMALE:							
Вох	leath certific attending p I for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	3 ☐Ectopic pregnancy	у				te of deliver	y Day Year
0	the a	/sic	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	5 Other (specify)						•
Д.	res that the de signed by the a be detached f	Ph	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause giv	en in Part I.	236	e. Did toba	cco use conf	tribute to the	e cause of death?
Records,	signe d be	d by	HO CVA with appasia	,g g			1 🗆 Yes	2 🗆 No	3 🗆 Proba	ıbly 4 ⊠ Unknown
Ö	w require been si should b	ete				24	a. Was an	24h	Were auton	sy findings available
e E	has ge 2 :	Completed				- 270	autopsy performe	ed?	prior to com death?	pletion of cause of
	n: Tł ficate vr. pa	င္ပ	25. Was case referred to medical		00 81	1 Death (Check		,	1 ☐ Yes	2 □ No
Ē	eicie s certi irecto	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outp	patient 3 DOA Oth	on	sing Home 5[er (Specify)	1
o	Phy er this eral d	-	27. Manner of Death 28a. Date of Injury 28b. Tir	ne of 28c. Injur		-		injury occur		
ion	nding th. r: Afte	atio	1 ★ Natural 5 Pending (Month, Day Year) Injuge 1 Accident investigation		nk?]Yes 2∐No	0				
Division of Vital	Attendi	iffici	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm building, etc. (Specify)	n, street, factory, office			ation (Stre		per or Rural	Route Number,
ō	tel or A s after el Direc ed in by	Certification:	Dullang, Go. (opposity)							
	To the Hospital or Attending Physicien: The Industrian 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/and manner stated.							
	To the To the	Me	29b. Signature and title of certifier	29c. Licens			290	d. Date signe	d (Month, D	Jay, Year)
	D		Verellorefold, MD	0005	7304	/		12/281	05	
	·		30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print)	Λ	1)		/		.22
			EIRENE KOROWLAKIS 10810 (Sinnecticut	HVENU	e, Ken	singf	en N	10 20	0842
	Sta Regist		30. Name and address of person who completed cause of death (Item 23a) (TEIRENE KOROULAKIS 10810 (3) 31. Date filed (Month, Day, Year) JAN 06 2006	goods						

Amend item#5, perFH, C352, 2/6/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year DECEMBER Victoria Fragale Kalin 30,2005 /Medical 5:30 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER 9. Birthplace (State or Foreign Country) I APLATA

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 233-32-8188 Usual Residence of Decedent 1 ☐ M 2**X** F 78 Yrs. Director July 16, 1927 West <u> Virginia</u> filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or itams 23a or 28s-f show the Mudical Examiner must be notified at 1 Yes 2 No Directo Maryland | Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 935 Copley Avenue 20602 U.S.A. 14. Race - American Indian, Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2/XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 Yes 2 X No þ Specify: White 3 XWidowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary permit. Pages 1 and 2 should be filed w Department of Heelth and Mental Hygie-Important: if item 27 is marked other tt any injury or other traumatic event, tha 9068. Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Francesco Samuel Fragale Catherine Veltri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20915 Quince Court, Calloway, Maryland, 20620 Jay F. Kalin / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beverly Hills Mem. Gdns. 1-5-2006 Morgantown, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01391 P.O. Box 156 Huntt Funeral Home Waldorf, Maryland 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwo Immediate Cause (Final disease or condition resulting in death) and Death **Physician** /Medical Examiner TEN SION Securities is conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or as a consequence of) Examine ete has been signed by the attending physicien and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical **fF FEMALE**: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?
1 Yes 3 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2. No this certificate 1 ☐ Yes 2 ☐ No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 P/Outpatient 3 DOA Certification: To herel Director; After the filled in by the funeral 27. Manner of Death
1. Natural
2 \(\text{Accident} \) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 Tes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Dec 31,2005 JAN 0 5 2006 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar	State of	Marylar		artment rtificate				lental Hyg	giene neg. Ne. 0	15	4380)
	Physici	an	Decedent's Name (First, Mide	fle, Last)							Date of Dea Month	Dav	Year	3. Time of De	eath
Marco	/Medic		Sandra	Ε.		K	rupsk				Decembe		2005	0335	М
8	Examin	ner	4a. Facility Name (If not institution	. •					Location o	of Death		4c. County		1 1	
5.50	- Funeral	3 -	Anne Arundel 5. Social Security Number			last birthday)	If Under	napo 1 Year	If Under	24 Hrs.	8. Date of Birth		Arun	del ace (State or F	Foreign
	Funeral Director		184-26-2735	1 ☐ M 2 💢 F	69	Yrs.	Months	Days	Hours	Min.	Feb. 8	(Year)	Coun	sylvani	-
	P		Usual Residence of Decedent									,			
	arylar e how	_	10a. State 10b. Count			ity, Town or Lo							10	Od. Inside City	
	8a-f	Director		Arundel	E	Annapol								1 🗌 Yes 🗶	TXINO
	with t	ä	10e. Street and Number 112 Meade Dri				10f. Zip					10g. Citizen of		try?	
	leath	Funeral	112 Meage DF1	12. Was Deced	lent Ever in U	IS 13 1		2140		ain? (Spe	orfy Yes or No-	US.	A. e - Americ	an Indian	
10	r iten	F	1 Never Married 2 Ma	Armed Ford	ces?	10.	f Yes, speci	fy Cubai	n, Mexican	n, Puerto	cify Yes or No- Rican, etc.)	Bla	ck, White,		
93	el'.o	ρ	3	If Yes Give			1 Yes 2	XX ₁ 0	Specify:			Specif	w Wh	ite	
21215-0036	72 hours after death with the Maryland "nature!, or items 23a or 28a-f ehow often Examinational be redified at	Completed		int's Education est grade completed)		16a. Deced	ient's Usual	Occupa	ition	t of worki	na	16b. Kind of B	usiness/Ind	lustry	
21	within lene. then	d d	Elementary/Secondary (0-12)		4or 5+)		kind of worl DO NOT use				•				
2	70		12 17. Father's Name (First, Middle	(aat)		Admin	istra	tive				Proper		nagemen	t
anc	a la b	Be	James Webster								(First, Middle,		ne)		
Maryland	should nd Men marke umatic	P P	19a. Informant's Name/Relation			19h Mailin	n Addrase	(Street a			Marshal Route Number		State 7in	Codal	
Ma	~ ~ ~ ~		Caryl A. Olie		er)						olis, MI		State, Zip	Ç00 <i>8</i>)	
ē,	s 1 and 3 f Health item 27 other tr		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nam	e of	1		ate	20c. Location -	City or To	wn, State	
9			1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3 ☐Removal from Si Specify)	tate	cemetery, crem etro Cr				12-31	-2005	Baltimo	oro l	ATD.	
Baltimore,	그는 문문		21. Signature of Funeral Service	/	110	22	. Name and	Addres	s of Facilit	v			ore, r	ш	
ä	Depa Impo eny ir		hund			•	Harde: 12 Rid	sty dge1	Funer	ral F	lome, P. Annapo	A. Mis. M	2140	11	
			23a. art1/Enter the dise s a c shook, or heart failure. Lis	or complications that can st only one cause on ea	used the deat								2,1,1	Approximate Interval Between	en
-	Pnysician		Im ediate Cause (Fina disease or condition	inel	envic	Can	/	_	·H					Onset and Dea	ath
	/Medical		resuring in death)	a. Due to (o		quence of):	liomy	rig	e i ny		,				
9	Examiner		Sequentially list conditions.	b. Coro.	nan		ay	12	sen	The					
	sit s	line	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	Due to (o	r as onseq	quence of):	0								
_	be executed Icien and burial-transit	Examine	that initiated events resulting in death) Last	c	r as a conseq	nuence of):									
8760,	be executed sicien and burial-transit				, 45 4 55.1554	(401100 5.7.									
687	et ye	Physician/Medical		d											
Вох	Jeath certifica attending ph	Z/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco								23d. Da	te of delive	v	
	death e atte d for	Icla	in the past 12 months?	4□Pregna	th 2 □ Feta nt at time of d		Ectopic pre Other (spe							Day Yea	ār
0	the ache	hys	9 □Unknown	9□ Unknov	vn										
o,		by P	Part II. Other significant condit	ions contributing to dea	th but not res	sulting in the ur	nderlyin g ca	use give	n in Part I.		23e. Did tol	bacco use cont	nbute to the	e cause of dear	th?
rd	requires seen sign hould be										1 🗆 Ye	es 2 🗆 No	3 Proba	ıbly 4 ∏Unk	nown
ec C	W 25 CA	ple									24a. Was a	n 24b.	Were autop	sy findings ava	ailable
Vital Records,	The la	Completed									perform	med?	death?	% No	JO 01
/ita	Physicien: Th this certificete ral director, pag	Be	25. Was case referred to medic examiner?							of Death	(Check only on	18)			
of	Physi this o	은	1 Yes 2000			ER/Outpatien			4 🗀 190		ne 5 Reside)	
E C	Jing f	on	27. Manner of Death Natural 5 Pend		Day Year)	28b. Time of Injury		c. Injury Work			.8d. Describe ho	ow injury accuri	ed		
isi	Attending ir death. ector: After by the fune	cat	3 ☐ Suicide 6 ☐ Could		f Injury At h	ome, farm, stre	M (asta-		es 2 🗆 l		8f. Location (SI	trans and \$1, mb		D 11 1-	
Division	if or Attend after death Director:	Certification:	4 Homicide deter	mined 288. Place of building	g, etc. (Specif	fy)	eet, ractory,	опісе			City or Town	reet and Numb n, State)	er or Hurai	Houte Number	r,
	spite		29a. Certifier 1 Certify	ing Physician: To the b	est of my kno	owledge, death	occurred a	t the time	e. date an	d place, a	nd due to the c	ause(s) and ma	nner as sta	ited	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	(Check only 2 Medica one)	Exeminer: On the bas and manne	is of examina	ation and/or inv	estigation,	n my op	inion, deat	th occurre	ed at the time, d	ate and place,	and due to	the cause(s)	
	withir To th	M	29b. Signature and title of certifi	er 1			1		number			9d. Date signed			
			11 6	1	V	np	r	200	576	335	- /	2, 2	9 21	ni	
			30. Name and address of person	who completed cause			Print)				mg. lis	-	1,0	·	
			1im wars	2001	medi	io/	PARK	un		Ano	melis	mo	214	0/	
	Sta		31. Date filed (Month, Day, Year JAN 0		gistrar's Signa	ature	1 .	1			U				
124	Registr	ar	JAN U	= ZUU0		St. A	2045	9							

			1 - For State Registrar	State o	of Marylan	-	artment of F rtificate of	lealth and N Death		giene 0	15	43802
			Decedent's Name (First, Middle	, Last)					2. Date of Dea	ath		3. Time of Death
	Physici /Medic		William Mor	ris Lipl	nam				Dec.	31, 2	005	8:10p M
	Examin		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City, Town, o	r Location of Death		4c. County	of Death	
			888 Windson					rnold			ne A	rundel
	Funeral		'	6. Sex 1 X M 2 ☐ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	y, Year)	9. Birthp Coun	
	Director		258-44-9449 Usual Residence of Decedent		73				May 29	, 1932		AL
	nyland how		10a. State 10b. County		10c. Cit	y, Town or Lo					1	0d. Inside City Limits
	Ba-f s	cto		Arundel			Arnold					1 ☐ Yes 2 ☑ No
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. Item 27 Is marked other then "natural", or Items 23a or 28a-f show other traumatic event, the Medical Exart and instituted at	Funeral Director	10e. Street and Number 888 Windsong Di	civo			10f. Zip Code	21012		10g. Citizen of V		itry?
	ns 23	eral	11. Marital Status		edent Ever in U	S 13 V	Was Decedent of H	Ispanic Origin? (Sp	pacify Vas or No-		JSA Americ	an Indian.
0	or Itan	Fun	1 □ Never Married 2 Marri	Armed Fo	orces? 2 □ No 1	949- '	f Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Blac	k, White,	etc.
	ral', c	d by	3 Widowed 4 Divorced	If Yes, Gir Year or D	ve Dates: 1	975	I□Yes 2.2XNo	Specify:		Specify		White
ה	"natu	etec	15. Decedent' (Specify only highes	s Education t grade completed)		(Give	lent's Usual Occup kind of work done	during most of worl	ring	16b. Kind of Bu	siness/Ind	dustry
7	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 4		00 NOT use retired Master Se			U.S.	Air	Force
2	Hygle Othar ant, I	യ	17. Father's Name (First, Middle, L	1	4			18. Mother's Nam	e (First, Middle,	Maiden Sumam	9)	
מומ	2 should be filed withir and Mental Hyglene. Is markad othar than aumatic evant, Ite Me	To B	Thomas Jeffers	son Lipha	m			Mary Mee	echam			
<u>a</u>	2 should and Men Is marka		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailin	g Address (Street	and Number or Rui	al Route Numbe	r, City or Town,	State, Zip	Code)
Ξ	and 2; ealth ar m 27 Is nar trau		Doreen Lipham,	/Wife				Drive, A		MD 210	12	
2	ges 1 t of H If ita or otl		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	3 □Removal from	State	emetery, cren	sition (Name of natory or other place	^(e) ∫.Tan	Date 6.	20c. Location -	City or To	wn, State
Dallino	it. Pa rtmen rtant: njury		'4 □Donation 5 □Other (Sp		MD		ans Cemet	ery	2006	Crown:		
ם	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra		21. Signature of Funeral Service L	icensee		Ba 49	arranco & 5 Gov. R	s Sons, P. itchie Hy	A. Seve	rna Parl	c Fun	neral Home
	3710		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that conly one cause on e	aused the deat						95000	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_a Co	lan (ancer	-					Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):						
		e	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conseq	uence of):					-	
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or Lijury that initiated events	-							11	
ĵ	an an rrial-tr	Еха	resulting in death) Last	Due to	(or as a conseq	uence of):						
	icate be executed physician and s the burial-transit	dical		d							-	
ŏ ≺		-	IF FEMALE:	220 If yes out	tooms of seasons							
2	es that the death certific igned by the attending p be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	tcome of pregna birth 2□Feta nant at time of d	death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	of deliver	ry Day Year
į	the d by the ached	Jysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkn		Jun 3	Oliter (specify)					
6	s that ned b e deta	by PI	Part II. Other significant condition	ns contributing to d	eath but not resi	ulting in the ur	iderlying cause give	en in Part I.	23e. Did to	bacco use contri	bute to the	e cause of death?
Ë	w require been sig should b								1 🗆 Y	es 2 No	3 🗌 Proba	ably 4 Unknown
י ט	e faw ra has be ge 2 sh	Completed							24a. Was a autops	an 24b. W	ere autop	esy findings available
	ding Physician: The h.n. After this certificate ha funeral director, page	Con							perfor	nged? d	eath? □Yes	
) I C	iclan certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Deat		ne)		
5	Phys ral dii	. To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatient 28b. Time of	3 DOA OUT	er: 4 ☐ Nursing Ho		ence 6 Othe)
5	th. After	tlon	1 Natural 5 Pending 2 Accident investig	(Mon	th, Day Year)	Injury	28c. Injury Work	(? Yes 2 □ No	200. Describe in	ow injury occurre	iu .	
2	Atter r dea actor by the	ertification;	3 Suicide 6 Could not determine	ot be 28e. Place			eet, factory, office			treet and Numbe	r or Rural	Route Number,
2	tal or rs afte al Dir	Cert	4 [] Holmidae	buildi	ng, etc <i>. (Specif</i>)	()			City or Towi	n, State)		
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a:	edical	29a. Certifier (Check only one)	Physician: To the xaminer: On the b and man	best of my kno asis of examinal ner stated.	wledge, death tion and/or inv	occurred at the timestigation, in my op	ne, date and place, pinion, death occur	and due to the cred at the time, d	ause(s) and mar late and place, a	ner as sta nd due to	ated. the cause(s)
	within To th compl	Me	29b. Signature and title of certifier			>	29c. License			29d. Date signed		
			1	2	/	mo	00	05549	5- 5	lanvara	3	2006
			30. Name and address of person w		se of death (Item	23a) (Type, F	Print)	5549. 5.16 363				
			Mark D. Ph. /i.p. 31. Date filed (Month, Day, Year)		900 Ba	5194 10	Kosed S	J. to 303	Annap.	dis m	0 7	21401
	Star Registra	_	JAN 0		Signal S Signal	B A	mente		,			
			26111.4		Contract Con		40000m/s//					

			1 - For State Registrar	State of I	Marylan		artment of H rtificate of L		d Mental Hy	giene,	05	43803
	Dharisi		1. Decedent's Name (First, Middle, La	ist)					2. Date of De		Year	3. Time of Death
	Physicia /Medic		Goldie Lucille	e Lewis						ber 2		5 1:00 pm
	Examin	er	4a. Facility Name (If not institution, giv		_		4b. City, Town, or		ath		inty of Death	
			4570 Port Taba 5. Social Security Number 6.5		d Age (In yrs.	last hirthday	Nanjer		rs. 8. Date of Bi		harle	
	Funeral Director			1 □ M 2 🔀 F	83	Yrs.	Months Days	Hours M		ay, Year)		place (State or Foreign htry) vland
	D D		Usual Residence of Decedent		03				May 20	, 1942	Pict	yrand
	aryłan show	_	10a. State 10b. County			y, Town or Lo					1	0d. Inside City Limits
	Se-f e	Director	Maryland Charle	S	N	anjemo						1 □ Yes 2√ No
	with ti	Dir	10e. Street and Number				10f. Zip Code				of What Cour	ntry?
	eath rs 23	Funerai	4570 Port Tobacco	Road 12. Was Decede	nt Ever in II	e 112 1	20662		(Specify Ven or N	U.S	.A. Race - Americ	on Indian
2	r Item	Fun	1 Never Married 2 Married	Armed Force	s?	.3.	Was Decedent of His If Yes, specify Cubar	n, Mexican, Pu	erto Rican, etc.)	J- 14. F	Black, White,	
Š	al', o Exer	by	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Date	•		1□ Yes 2□XNo	Specify:		Spe	ecity: Blac	ck
ה ה	be filed within 72 hours after death with the Maryland Hygiene. dother than "natural", or Items 23a or 28e-f ehow dother than "natural", or Items 23a or 28e-f ehow avent, the Madical Evaninar must be nutified at	Completed	15. Decedent's E (Specify only highest gra			16a. Dece	dent's Usual Occupa kind of work done of	ition fu <i>ring most of</i> i	vorkina	1	f Business/în	
7	vithin ne. han *	mpi	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT use retired,)	9			
7 7	iled v Tygie ther t		12 17. Father's Name (First, Middle, Last	2			Nurse	19 Mathoda N	lame (First, Middle		spital	
<u> </u>	d be a	o Be	William Oscar Po					Nelli	_	101000	iame)	
<u> </u>	shoul nd Me mark	2	19a. Informant's Name/Relationship (19b. Mailir	ng Address (Street a			WSON er. City or Tox	wn. State. Zio	Code)
Ž	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Braning or them 27 is marked other than "natural" or ttems 23a or 28e-f show any injury or other traumatic event, the Madical Examinat must be nutified at once.		Debra Posey Thoma	s Niece	9		Bucknell					*
ກັ	of Hei		20a. Method of Disposition			lace of Dispo	sition (Name of	9)	Date		on - City or To	
≝	Page nent cant: If ant: If		1 Deurial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Special		Chu	rch of	sition (Name of matory or other place The Lord	Jan. Jesus	Christ	Trons	ides. J	Maryland
Daltillion	ppartri pports y inju		21. Signature of Funeral Service Lice	nsee			Name and Addres					20640
0	20 F # 9		23a. Part1. Enter the disease, or comshock, or treart fallure. List only	ly		668 4	270 Haw1	thorne	Rd. I	ndian	Head	, Md.
	Physician and /Medical Examiner sthe private and sthe private street str	ai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CAn Due to (or Due to (or c.	as a consequence as a c	uence of):	Cow	N :				Interval Between Onset and Death
0	physic the	dicai	•	d								
O. DOX	death certif e attending d for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ►No 9 □ Unknown		2 ☐ Fetel t at time of d	Ideath 3	Ectopic pregnancy Other (specify)				Date of delive Month	ory Day Year
r.	The law requires that the ste has been signed by thi page 2 should be detache	by Ph	Part II. Other significant conditions	contributing to deat	h but not resi	ulting in the u	nderlying cause give	n in Part I.	23e. Did 1	tobacco use c	ontribute to th	e cause of death?
cords,	quires an sig uid be								1 🗆	Yes 2□No	3 □ Prob	ably 4 Unknown
ວ	aw re	ompieted							24a. Was	an 24	b. Were auto	psy findings available
	: The law cate has I	mo							auto perfo 1 ☐ Yes	psy ormed? 2 W No	death?	npletion of cause of
NI CA	ysicien: The is certificate director, pag	Be C	25. Was case referred to medical examiner?					26. Place of D	eath (Check only			
> 5	di S	To	1 ☐ Yes 2 KNo	Hospital: 1 🗆 Inp		ER/Outpatien	nt 3□ DOA Othe	4 Nursing	Home 57 Resi	dence 6 🗆 0	Other (Specify	<i>ı</i>)
=	ding Ph J. After th funeral	ion:	27. Manner of Death 1 Natural 5 □ Pending		njury Day Year)	28b. Time of Injury	Work	?	28d. Describe	how injury occ	curred	
VISION	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	ertification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	28e. Place of	Injury - At ho	ome, farm, str	M 1 □ Y	′es 2□No	28f. Location (mber or Rura	l Route Number,
	urs afi	O										
	a Hosp 24 hor a Fune etely fi	edicai	29a. Certifier 12 Certifying Pt (Check only 2 Medical Examone)	nysician: To the be miner: On the basi and manner	s of examina	wledge, death tion and/or in	n occurred at the tim vestigation, in my op	e, date and pla inion, death oc	ice, and due to the curred at the time,	cause(s) and date and plac	manner as st e, and due to	ated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	LA)		29c. License	number		29d. Date sig	ned (Month,	Day Year)
		-	Jun Kt	LAUR	Lit	w.	D -	206	29	12	130	105
0	20		30, Name and address of person who	completed cause of	death (Item	1 23а) (Туре.	Print)	1 (0	0.00	000	0 -	72
,	000	,	TI-DARCHE	N. M.	1477	Then	LMJ.	MA	WOLL	L I VI	UL "	-0603
	Sta	ite	31. Date filed (Month, PAY) ear)	2006 32. R	strar's Signa	liure &	Anail .					-

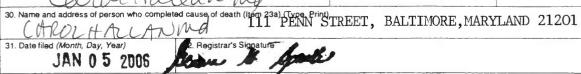
			1 - For State Registrar	State	of Marylar		artmer rtificat					giene Reg. No.	005	438	04
	Physici		1. Decedent's Name (First, Middle, L Shirley				Land	on			2. Date of De Month Decembe	Day	2005	3. Time of 10:15	Death D ^M
	/Medio		4a. Facility Name (If not institution, g		ımber)				Location of		Decembe		County of Dea		p
	LAdiiii	ici	307 Stanford Roa	ad				trev				Qu	een An	nes	
(*)	Funeral Director		578-42-1021	Sex 1□M 2□F	7. Age (In yrs. 71	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da Dec. 28	y, Year)	C	thplace (State of ountry) ryland	r Foreign
7	2 3		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside Cit	ty Limits
de de de de de de de de de de de de de d	1 eho	ō	MD Queen A	\nnes	C	entrev	1110							1 ☐ Yes	•
4	or 28e	Director	10e. Street and Number	iiiico		CHCIEV.		Code				10g. Citiz	en of What C	ountry?	
40	23a c		307 Stanford Roa					21617					US	Α	
00	is raint's strong be there within the roles are been with the maryan of Health and Mortal Hygiene. It fem is not strong to the marked other then "natural", or items 23e or 28e-f show other traumatic event, the Modical Examinat must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ፟ Married 3 ☐ Widowed 4 ☐ Divorced	Armed F	2 📉 No ive		Was Dece f Yes, spe 1 ☐ Yes		spanic Ori n, Mexican Specify:		cify Yes or No Rican, etc.)		 Race - Ame Black, White Specify: 		
0000-0	atura	ted	15. Decedent's	Education		16a. Deced	dent's Usu	al Occupa	ition			16b. Kin	d of Business	/industry	
7 7	Mod n	Completed	(Specify only highest of Elementary/Secondary (0-12)		1-4or 5+)	life.	kind of wo DO NOT u	ork done d ise retired,	uring mos	t of workii	ng				
7	Hygien her th		11 17. Father's Name (First, Middle, La.	st)		Homen	naker		18 Mothe	or's Namo	(First, Middle		Home		
מוומ	ontal h	o Be	Robert L. Smith	51)					Rose			, маюел з	umame)		
֓֞֞֞֜֞֜֞֝֞֜֜֝֓֓֓֓֓֜֜֜֜֓֓֓֓֓֓֓֡֓֜֜֡֓֓֓֓֡֓֜֡֓֡֓֡֡֡֓֜֡֡֡֓֡֓֡֡֡֡	nd Me mark	2	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	s (Street a			l Route Numb	er, City or	Town, State,	Zip Code)	
N S	alth a		Walter Landon (H	usband)		307 S	Stanf	ord F	Road,	Cent	trevill	e, M	21617	7	
	of He of He or oth		20a. Method of Disposition 1208urial 2 ☐ Cremation 3	☐Removal from	State 20b. I	Place of Dispo cemetery, crer	natory or o	me of other place	9)	D	ate	20c. Loc	ation - City or	Town, State	
Daitimor	tment of tant: If it tant: or o		4 Donation 5 Other (Spec	cify)		kemont					L-2005		lsonvil	lle, MD	
ם	Department of Important: If ite any injury or of other		21. Signature of Funeral Service Lic	A W	eld 1	22	Hard 1∠ R	esty idge.	Fune Fune Ly Av	ral enue	Home, I , Annap	P.A.	, MD 2	1401	
00,	Physician /Medical Examiner ponujai-itansit	dical Examiner	23a. Part1. Enter the disease, shock, or heart failure. List on immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	a	each line.	quence of):	er the mod	se or dying	, such as	cardiac	respiratory a	rrest,		Approximate Interval Betwonset and D	ween
DOY O	e attending	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	1 Live	utcome of pregni birth 2 Feta nant at time of c	al death 3	Ectopic p Other (sp					23	3d. Date of de Month		ear ear
necords, r.O	been signed bestonder	þ	Part II. Other significant conditions DiABerey Mellin		death but not res	sulting in the u	nderlying o	ause give	n in Part I.			obacco us Yes 2		o the cause of di robably 4 🗀 U	
		Completed									24a. Was autor perfo	osy ermed?	death?	utopsy findings a completion of ca	available ause of
710	is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only o				
5 5	After this c	lon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date	Inpatient 2 of Injury oth, Day Year)	28b. Time of Injury		28c. Injury Work	4 🗆 INU	2	ne 5 Resi			cify)	
DIVISION	in the nospirer or Attending Frigations. Within 24 hours elicit death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification:	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Plac	e of Injury - At h ling, etc. (Special	ome, farm, str fy)					28f. Location (. City or Tou	Street and vn, State)	Number or R	ural Route Numt	ber,
	within 24 hours To the Funera completely fille	edical C	29a. Certifier 1 X Certifying (Check only one) 1 Medical Ex	Physician: To th aminer: On the l and mar	e best of my kno casis of examina nner stated.	owledge, death	occurred vestigation	at the tim	e, date an inion, dea	d place, a	and due to the ed at the time,	cause(s) a date and p	nd manner a	s stated. a to the cause(s)	
,	Withi To the	¥	29b. Signature and title of certifier					c. License				,	,	h, Day, Year)	
			J. O. UKE	- 7	-		V	63	147			12/2	1/05		
			30. Name and address of person wh	o completed cau	se of death (Iter	m 23a) (Type,	Print)	0.1	0	1	11 -	100	2 211	17	
Toron.	St	ate	31. Date filed (Month, Day, Year)	32.	se of death (Iter 2540 Begistrar's Signa	ature	VITE	L.O	Le	~341 E	wille	44/1	الد ر	91 (
	Regist		JAN 9 4	2006	Color	1 1	The also								

			1 - For State Registrar	State of N	Marylan		artment rtificate			ind Me		iene		43805
	Physici	an	Decedent's Name (First, Middle, L								2. Date of Deat Month	h Day	Year	3. Time of Death
OF STATE	/Medic	al	Alfred Leo Leud 4a. Facility Name (If not institution, g				4h Cib. T	Faura ar	Location o		Decembe		2005	12:00 PM
1	Examir	ier	374 Colony Point		91)		46. City, 1		ewate					rundel
	Funeral		Social Security Number 6.		Age (In yrs.	last birthday)	If Under 1		If Under 2		8. Date of Birth (Month, Day,	Voar	9. Birth	place (State or Foreign ntry)
	Director	3	066-10-0764	1 X M 2□F	92	Yrs.	Months	Days	Hours		May 2,1	913	New	York
	land w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Many -1 sho	tor	Maryland Anne Ar	un de 1		Edg	ewate	r						1 ☐ Yes 2 📉 No
	h the or 28a	irec	10e. Street and Number				10f. Zip (1	0g. Citizen o	of What Cou	ntry?
	death with the Maryland ms 23a or 28a-f show finant be notified at	rat D	374 Colony Point	Place			21	037				Unite	d Stat	es
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination must be rediffied at Once.	by Funeral Directo	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	s? ∑No	1	Was Decede f Yes, speci 1 ☐ Yes 2	fy Cubar	spanic Orig n, Mexican Specify:	gin? (Spec , Puerto P	cify Yes or No- lican, etc.)			
20	72 ho	ted	15. Decedent's (Specify only highest g			16a. Dece	dent's Usual kind of work	Occupa	tion	of workin	0	16b. Kind of	Business/In	
2	nthin ne ne Me	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life. I	DO NOT use	e retired)		or working				
2	Hygier Hygier Ther th		17. Father's Name (First, Middle, La:	2		F.	irefi	gnte		r's Name	(First, Middle, M		epartm	ent
and	d be f	o Be	Adolph Emma		a do ref	£							· ·	
Maryland	shoul nd Me mark	ဥ	19a. Informant's Name/Relationship		58 GO I I		ng Address ((Street a			Route Number,			Code)
ž	and 2 alth a 127 la		Linda F. Gr ee n / 1	Daughter		971 F	irst :	Stre	et, B	atav	ia, IL	60510)	
altimore,	of He fiterr		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	□ Removal from Sta	20b. P	lace of Dispo emetery, cren	sition (Name	e of her place)	Da	ite :	20c. Location	n - City or To	own, State
Ĕ	Pag ment lant: I		4 Donation 5 Other (Spec	city)	For	t Linco						Brentw	ood, 1	Maryland
- Ball	Depart Depart Import any in		1. Signal of Funeral Service Lic	. Tull	0									Home, Inc.
100	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury)	a. Due to (or	as a consequence	acuence of):	er the mode	_	such as c		respiratory arre	est,		Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	licai Examiner	that initiated events resulting in death) Last	c Due to (or a	as a consequ	uence of);								
P.O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknown	2 Fetal	death 3	Ectopic pre Other (spe						Date of delive	ery Day Year
	w requires that been signed k should be deta	þ	Part II. Other significant conditions	contributing to death	but not resu	ulting in the ur	nderlying ca	use give	n in Part I.		İ	acco use co s 2 Mo		ne cause of death?
of Vital Records,	: The law re cate has bea page 2 sho	Completed									24a. Was ar autops perform 1 Yes 2	,	prior to con death?	psy findings available mpletion of cause of
Σ Σ	certifi	Be	25. Was case referred to medical examiner?	Hospital:				Othe	-		Check only one			
of	Attending Physician: r death. ector: After this certifics by the funeral director.	1: 10	1 ☐ Yes 25 No 27. Manner of Death	1 ☐ Inpa	njury	ER/Outpatien 28b. Time of		`	4 🗆 1401	sing Hom	e 5 Reside			y)
lon	nding th. :: Afte	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigati		Day Year)	Injury	м	lc. Injury Work 1 🗆 Y	? es 2∐N					
Division	er dea	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 286. Place of	Injury - At ho	ome, farm, stre	eet, factory,	office		28	3f. Location (Str City or Town	eet and Nur	nber or Rura	l Route Number,
ō	ital or A rs after ral Directed in by	Cer												
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	one)	Physician: To the be aminer: On the basis and manner	of examinal	wledge, death tion and/or inv	occurred a vestigation, i	t the time in my op	e, date and inion, death	place, ar h occurred	nd due to the ca	use(s) and r ite and place	mannor as si e, and due to	tated. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	· n-					number		29		ned (Month,	Day, Year)
			Mulau					dy	768			1/3/	U6	
			30. Name and address of person who William A. Dabbs,	· ·	-			d	Arno1	d. M	D 21012			
	Sta		31. Date filed (Month, Day, Year)		strar's Signa			,		,				
	Registr		JAN 0 4	2006	dia	R A	houle	6						

			1 - For State Registrar	State of Maryl		artment of rtificate of			iene 9. %. 0 0 5	43806	
	Physici		Decedent's Name (First, Middle, Last) John. R. Mo.	cton, Sr.				2. Date of Deat Month December	Day Year	3. Time of Death 13:55	1
	/Medic Examin		4a. Facility Name (If not institution, give s	reet and number)		4b. City, Town,	or Location of Death		4c. County of Dea		_
			Washington Adventist I				ma Park		Montgomen		
	Funeral Director		5. Social Security Number 251–42–8340 6. Sex 1 ☑	7. Age (In)	yrs. last birthday) 73 Yrs.	Months Days		8. Date of Birth (Month, Day, December	^{9. Bir} 25, 1931 Sc	thplace (State or Foreign ountry) uth Carolina	7
	and w		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	cation				10d. Inside City Limits	_
	e Maryli 3a-f aho lillied a	Director	Maryland Prince G		,	Hyattsv	ille			Maryes 2□No	
	h with th	al Dire	10e. Street and Number 6839 Standish Drive	9		10f. Zip Code	20784	10	og. Citizen of What Co U.S.A.	ountry?	
920	n 72 hours after death with the Maryland "natural", or Itams 23a or 28a-f ahow polical Examinational be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Bla	te, etc.	_
Maryland 21215-0036		Completed	15. Decedent's Educ (Specify only highest grade Elementary Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	dent's Usual Occi kind of work don DO NOT use retir	upation a during most of work ed)	ding	16b. Kind of Business		_
land 2		To Be Co	17. Father's Name (First, Middle, Last) Unknown					e (First, Middle, M Eloise Rob	faiden Sumame)		_
Mary	D € 22		19a. Informant's Name/Relationship (Typ Mrs. Lucille Morton (Wit	•					City or Town, State, J		
Baltimore,	of ff if		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)		b. Place of Dispo cemetery, crer tarmony Mer	natory or other pl	ace)		Landover,		
Balti	permit, Pag Department Important: I any injury o		21. Signature of Funeral Service License	n day &					al HOme, Inc , D.C. 2001		
	/Medical Examiner	Examiner	23a Fant. Enter the disease, or complication ock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Lines to userlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):	er the mode or dy	Olseoje	or respiratory arre	St,	Approximate Interval Between Onset and Death	
, P.O. Box 68760,	that the death certificate ed by the attending phy: detachad for use as the	y Physician/Medicai	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions continued in the past 12 months?	c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	Fetal death 3 Cof death 5 C	Ectopic pregnani Other (specify)		23e. Did tob	23d. Date of del Month	Day Year	
Vital Records,	w requires been sign should be	ompieted by					·			obably 4 Unknown	
al Rec		O		-				24a. Was an autopsy perform	prior to	topsy findings available completion of cause of 2凶No	
Vit	Physician: This certificatal director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 XNo	spital: 1 ☐ Inpatient 2	2 XER/Outpatien	27704	hor	h (Check only one			
on of		H .	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of	28c. Inju	4 Li Nursing Ho	28d. Describe hov	nce 6 Other (Sperwinjury occurred	orty)	-
Division	or Attsni after deat Diractor: in by the	ertification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, streecify)			28f. Location (Str. City or Town,	eet and Number or Ru State)	ıral Route Number,	
_	urs urs aral	edical Co	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	cian: To the best of my er: On the basis of exam and manner stated.	knowledge, death nination and/or inv	occurred at the trestigation, in my	ime, date and place, opinion, death occur	and due to the car red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)	_
	To the Hosp within 24 ho To the Funs completely f	Me	29b. Signature and title of certifier	/		29c. Licen	se number	29	d. Date signed (Monti	n, Day, Year)	_
			· 14 /			SG	428		114/06	2	
2	(10)	s. 10	30 Name and address of person who con	pleted cause of death (Print)	fre. Tok	ena	Revie M	11) 20912	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 6 2006	Registrar's Si	gnature	BI	,			3	

K.S	S MARY MC	ΩD	F Ple	ase Type or P							•		
SA.	PIART PIC	OK.	For 1 State	State of	Maryland /		artment of H				2005	1,38	0.7
			Registrar			Ce	rtificate of l	Jeath		Reg.	N6- 0 0 0	700	0 /
	Physicia	ın	1. Decedent's Name (First, Mid						Mor	ith	Day Year	3. Time of	
	/Medic		Lisa Mary Mo				1			C. 31		2040	РМ
	Examin	er	4a. Facility Name (If not instituti 3398 COX ROAI)			4b. City, Town, or CHESAP	EAKE	BEACH		4c. County of Deat CALVERT		
	Funeral Director		5. Social Security Number 219-86-2317	6. Sex 7 1 ☐ M 2 🖾 F	Age (In yrs. last b		Months Days	If Under Hours	24 Hrs. 8. Date (Mor. Jul	of Birth oth, Day, Ye y 1,	ear) 9. Bird Co 1965 Mar	hplace (State of untry) yland	r Foreign
	pue ≱_	ŀ	Usual Residence of Decedent 10a. State 10b. Coun	tv	10c. City, Tov	vn or Lo	ocation					10d. Inside Cit	ty Limits
	faryli eho	5	VD 0-1		61							1 ⊊ Yes	2 🗆 No
	28a-	ect	MD Calve	ert	Chesa	pea	10f. Zip Code			100	Citizen of What Co	unto/2	
	permit. Peges t and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Importent: If Item 27 ie marked other then "natural", or Iteme 23a or 28a-f ehow any injury or other treumatic event, the Medical Examinar must be notified at once.	Funeral Director	3398 Cox Road	1			20732				.S.A.	and y .	
	ne 23	era	11. Marital Status		ent Ever in U.S.	13.		ispanic Or	igin? (Specify Yes		14. Race - Ame	nican Indian,	
	ter d	5	1 ☐ Never Married 2 ☐ Ma	Armed Ford	es?		Was Decedent of H If Yes, specify Cuba	ın, Mexicai	n, Puerto Rican, e	tc.)	Black, Whit		
336	irs af	<u>A</u>	3 ☐ Widowed 4 反 Divorce	If Yes Give			1 ☐ Yes 2 ☒ No	Specify:			Specify: Wh	ite	
21215-0036	2 hou	Completed by	15. Decede	ent's Education	168	a. Dece	dent's Usual Occup	ation		166	o. Kind of Business/	Industry	
215	Media	ple	(Specify only high Elementary/Secondary (0-12	nest grade completed) College (1-4	4or 5+)	life.	kind of work done of DO NOT use retired	during mos ()	st of working				
21	d wit	E C	12		,	ait	ress				Food		
P	ai Hy ai Hy I oth	Be (17. Father's Name (First, Middle	e, Last)				18. Moth	er's Name (First, i	Middle, Mai	den Sumama)		
Maryland	2 should be filed within 72 hours after dee and Menial Hygiene. Ie marked other then "natural", or Iteme 'eumatic event, I'm Medical Examinat m	2	Robert F. Ber	cnhardt					y Ann Gr				
lar	and and iem		19a. Informant's Name/Relation				ing Address (Street					67	
	and ealth m 27		Michael R. Mo	oore, Jr			9 Evening			-			
Baltimore,	ges to the Hite			a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory of other place) Ft. Lincoln Crem. 20c. Location - 0 20c. Loc									
Ë	tmen tent:				Ft.						entwood,		
Bai	Depermit Depermit Import any ir		21. Signature of Funeral Service	ce Licensee	1		2. Name and Addres		FC. L1		Funeral		
	40244	_	23a. Part 1. Enter the disease,	a. Coppe			3401 Blad	ensbu	rg Rd.	Brent	wood, MD	20722 Approximate	
			shock, or heart failure. Li	st only one cause on ea	ch line.					atory arrest,		Interval Bety Onset and D	ween
J.	Physician		Immediate Cause (Final disease or condition resulting in death)				end to	Heac	1				
	/Medical Examiner		rosalling in osalli,	Due to (o	r as a consequence	of):							
		-	Sequentially list conditions, if any, leading to immediate	b. Due to fo	r as à consequence	off.							
	ted nslt	in in	Cause (Disease or injury	≺		,							
	death certificate be executed e ettending physicien and id for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (o	r as a consequence	of):							
68760,	sicie	_		d									
.89	ificate g phy as the	edic										*****	
Вох	n cert	2	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy	h a[□Ectopic pregnancy				23d. Date of del	ivery	
	death	Physician/Medica	in the past 12 months? 1.□.Yes 2 □ No		nt at time of death		Other (specify)				Month	Day Y	rear .
P.O.	that the dened by the e	hys	9 Unknown	3 Oliviloa	VII								
	Se Pag	þ	Part II. Dther significant condi	itions contributing to dea	ith but not resulting	in the t	underlying cause giv	en in Part I	1. 236		co use contribute to		
Records,	w requires been sign should be	ted								1 🗆 Yes	2 XNo 3 □ Pr	obably 4 □U	Inknown
ပို	> 10	Completed							248	. Was an autopsy	prior to	topsy findings a	available ause of
<u> </u>	The ete ha	Con							11)28	performed Yes 2		2□ No	
Vital	clan: Brtific octor,	Be (25. Was case referred to medie examiner?						e of Death (Check	only one)			
7	Physician: r this certific rel director,	ပ္	1 XYes 2 No				nt 3□ DOA Oth	4 🗆 191			e 6XXOther (Spe	city) AT S	CENE
ū	ing P	on:	27. Manner of Death 1 □Natural 5 □ Pend	ulling 1	, Day Year)	Time o	Wor	y at k?		,	njury occurred		
Sic	Attending r death.	cat	2 Accident inver 3 Suicide 6 Cou	stigation 12 3			PM 10	Yes 2	1	chiec	t and Number or Ri	um l Pareto Alesmi	bor
Division of	or Al etter of Direction by	Certification:		mined 286. Place o	of Injury - At home, g, etc. (Specify)	iai(II, St	Teet, Tactory, Office		City	or Town, S	(tate) 3398 C	OX Rd	JG1,
	To the Hospital or Attending Physician: The law within 24 hours efter death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2.	Č.	29a. Certifier 1 ☐ Certif	ying Physician: To the b	SIDELLE SIDE SIDE SIDE SIDE SIDE SIDE SIDE SID	e, dea	th occurred at the tin	ne, date ar			e(s) and manner as	stated.	
	Hos 24 h Fur etely	edical	(Check only 2 Medic one)	al Examiner: On the bas	sis of examination a	ind/or in	nvestigation, in my o	pinion, dea	ath occurred at the	time, date	and place, and due	to the cause(s))
	To the within To the compl	Me	29b. Signature and title of certi	fier			29c. Licens				Date signed (Mont		
) (aha	e Halla	n mid		0.	C.M.E	i .	J.	AN. 1, 20	006	
- /	1/4				V V								

State Registrar



State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Physician 1:20 P.M. PHYLLIS **MELITO** Μ. 12 31 2005 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner ASBURY-SOLOMONS NURSING HOME SOLOMONS CALVERT If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Dey, Year) Days Months Hours Min. 1 □ M 2 StF Director 579-48-7663 72 12-26-1933 WASHINGTON, D.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If them 27 is merked other than "natural" any injury or other traumetic examples. 10e, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1. Yes 2 □ No Director MARYLAND HUNTINGTOWN 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3502 RANDY DRIVE 20639 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: WHITE 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 **SECRETARY** U.S. GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BERNARD L. GORMELY PATRICIA TALLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BERNICE M. MELITO- DAUGHTER 8110 McCLURE RD., UPPER MARLBORO, MD 20772-8404 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State MELSON'S CREMATORY 5 □Other (Specify) 1-7-06 4 Donation FRANKFORD, DELAWARE 22. Name and Address of Fecility MELSON FUNERAL SERVICES, LTD. 21. Signature of Funeral S OCEAN VIEW, DELAWARE 19970 23a. Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical & END STAGE CHRONIC UBSTRUCTIVE PULMONARY DISPARTY FARS Examiner Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificete be executed use es the buriel-trensit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical Due to (or as e consequence of) Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Linknown DISFAJE ARTORA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed CARD VAL 2 NU IL Yes 1 ☐ Yes 2 ☐ No ours after death.

eral Director: After this certificatilled in by the funerel director, I 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 4 3-Hdrsing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ⊌Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 / Homicide within 24 hours a

To the Funeral C

completely filled 1 critifying Phyeiclan: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 02635 30. Name en address of person who completed cause of death (Item 23e) (Type, Print) Jo 6-2 PRINCE WE Z 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 8 2006 Registrar

Amend Item 3 per ME, G852, 02/16/06dhb Death 1 - For Stete Registrar Reg. No.--1. Decedent's Name (First, Middle, Last) 7:41p 2 Date of Death Physician Month Year Justin Frank Miller December 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Smallwood Drive Crain Highway / Waldorf Charles 7. Age (In yrs. last birthday)
21 Yrs. Months Days Hours Min. (Month, Day, Year)
0ct. 30, 1 5. Social Security Number 6. Sex **Funeral** Birthplace (State or Foreign Country) 1 XM 2 F 219-15-1078 Director 1981 Marvland Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinar must be notified as once. 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Charles LaPlata 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 20646 6240 Home Place U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician Commercial Electrical 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) James Robert Miller, Sr. Debra A. Stelzer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20732 19a, Informant's Name/Relationship (Type, Print) James R. Miller, Sr. / Father 3820 Chesapeake Beach, Chesapeake Beach, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gdns. 01-06-2006 Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01391 Littyst P.O. Box 156 Huntt Funeral Home Waldorf, Maryland 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multiple injunies /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, is a fine to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physiclen and the burial-transit Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 980 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cate has been signated by page 2 should b 1 Yes 2 X No 3 Probably 4 Unknown Completed 24a. Was an this certificate Yes 2 🗌 No Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 XX ther (Specify Scene 얼 1√√Yes 2 No After thi 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending investigation redestion strek by wehicle death. 7:21 Dec 31,2005 1 Tes 2 No PM within 24 hours after death To the Funeral Director: , completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Craw Huy 301, WaldwA, MD determined 4 Homicide Hospitel hva 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD OCME January 1, 2006 30. Name and address of psison who complet use of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Tasha Z Cirechan MD 31. Date filed (Month, Day, Year) 32. R strar's Signature State

DHMH 17 Rev 1/2001

Registrar

JAN 05

2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 04:44 AM Samuel Norris December 31, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore City The Johns HOPKINS HOSPITAL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Jan 24 Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 285-205000 1**∑**M 2□F 78 Director Yrs. 1927 Georgia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Medical Examinar must be invitiled at Maryland Anne Arundel Glen Burnie 1 Tyes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 216 Warfield Rd. 21060 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ★Yes 2 □ No If Yes, Give Year or Dates: 1945-46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married XXMarried 1 ☐ Yes **②**OXNo Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Printer 12th Cincinnati Inquier 1yr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be find Mental H marked of Clifford Norris Georgia Thornton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Itam 27 Frances Norris(Wife) 216 Warfield Rd. Glen Burnie, Md. 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 ō <u>=</u> t X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Deportment of Important: If any njury or once Maryland Veteran 1-9-2006 * 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Md. wm. Reese & Sons Mortuary, 21. Signature of Funeral Service Licenses Larry D. Been MO6483 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the insease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CArdiogenic Shock 10 DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Anterior WOLL MYDCARDIAL INFARCTION 10 0045 Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): attending physicien for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No the detached 9☐ Unknown 9 Unknown è cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 No 1X Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation M after death 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MEDICAL DOCTOR RES-000 December 31, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Timothy Scialla, The Johns Hopkins Hospital, GOO NORTH WOLFE Street, BALTIMORE MORYLAND 21287 Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 0 5 2006 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1 For State RegistrarAmend Item	State of Mary					nd Men		- 401	05	43811
	Physic /Medi		1. Decedent's Name (First, Middle, Last ROBERT LEE NUNN		'H G851	17277	06°J	H ·····	1	Date of Deat Month ECEMBE	Day	Year	3. Time of Death
	Exami		4a. Facility Name (If not institution, give			4b. City		Location of		CEMBE	4c. Count		6:00P [™]
	Funeral Director		5. Social Security Number 6. Se		yrs. last birthday 81 Yrs.) If Under Months	r 1 Year	If Under 24	Min. (Date of Birth Month, Day, CT. 17	Year)	Coun	lece (State or Foreign
	the Maryland r 28a-f show	rector	10a. State 10b. County MD MONTGOM 10e. Street and Number		:. City, Town or L	SPRII	NG p Code			10	g. Citizen of		Od. Inside City Limits XXYes 2 □ No
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or lieme 23s or 28s-f show other traumatic avent, the Medical Exemples must be multilled at	by Funeral Director	3215 SOUTH LEISUR 11. Marital Status 1 Never Married XXMarried 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? XIX Yes 2 □ No If Yes, Give			2 dent of Hi ecify Cuba	20908 spanic Origin n, Mexican, F	n? (Specify Puerto Ricar		UNITE:		TES an Indian, etc.
121	filed within 72 hour Hygiene. other than "natural ent, the Medical Ex	Completed	15. Decedent's Edi (Specify only highest grad	Year or Dates: cation e completed) College (1-4or 5+) 5+	16a. Dece (Give lifa Specia	dent's Usu kind of wo DO NOT u al As COAL	ork done d Ise retired SIST	furing most o	of working the Direct		6b. Kind of B Federa	usiness/Inc	
aryland	2 should be filed and Mental Hygie la marked other sumatic avent, It	To Be C	17. Father's Name (First, Middle, Last) FLETCHER NUNN 19a. Informant's Name/Relationship (Ty		19b. Maili			18. Mother's	s Name (Firs	st, Middle, M	aiden Suman	ne)	Code)
σ			MURIEL NUNN / WIF 20a. Method of Disposition XXBurial 2 Cremation 3 CP	lemoval from State	3215 b. Place of Disponentery, cre	S. LI osition (Nam matory or o	EISUR me of other place	E WORI	LD BLV	D. #21		ER SPI	RING,MD
Baltir	permit. Page Department of Important: If any injury or once.	16 J	4 Donation 5 Other (Specify) 21. Signature of Bunefall Marvice Liceny	L		2. Name ar MARSI 4308	Addres IALL SUIT	s of Facility S FUNE LAND R	ERAL H ROAD	OME OI	F MARYI	LAND, LAND, MD 207	INC.
	/Medical Examiner	mlner	23a. Parft. Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Eine Underlying Cause (Disease or injury)	LEUKEMIA Due to (or as a con	sequence oi):	ter the mod	de of dying	g, such as ca	rdiac or resp	piratory arres	st,		Approximate Interval Between Onset and Death
Box 6	If the death certificate be executed by the ettending physicien and tached for use as the burial-transit	Physician/Medicai Examin	IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 9 \(\text{Unknown} \)	Due to (or as a con. 1. 3c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	gnancy etal death 3[]Ectopic pr			J.T.		23d. Dat Mo	te ol deliver	y Day Year
ords, P.O.	iaw requires mat me as been signed by th 2 should be detache	ρ	Part II. Other significant conditions con		resulting in the u	nderlying c	ause give	n in Part I.	2		_		e cause of death?
ital Rec	ate h	Be Completed	25. Was case referred to medical examiner?					26. Place of	11	4a. Was an autopsy performe	ed?	Were autoportion to combeath?	sy lindings available pletion of cause of 2 No
vision	Attending Physic death.	Certification; To	1 Yes 2 No H 27. Manner of Death XIV Natural 5 Pending investigation 3 Suicide 6 Could not be determined	ospital: MXInpatient 2 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - A building, etc. (Spe	t home, larm, str	M 2	8c. Injury Work	[□] 4 □ Nursir	28d. D	5 ☐ Residen escribe how	ce 6 Other	ed	Route Number,
	within 24 hours after To the Funeral Dir completely filled in	edicai Ce	29a. Certifier (Cluck onl) one) XX Certifying Phys 2 Medical Examin	ician: To the best of my lier. On the basis of exam and manner stated.	knowledge, death ination and/or in	occurred ;	at the time	e, date and pi	lace and du	io to the one		nner as sta and due to t	ted. he cause(s)
	Somp	Me	29b. Signature and title of certifier	S. Wilk			License	number 3195			. Date signed		
	Star Registra		30. Name and address of person who con STEVE WILKS, MD 31. Date filed (Month, Day, Year) JAN 0 5 2006	8600 OLD G	EORGETO		AD	ВЕТНЕ	SDA, M	1D 208	16	200000	2000

			For Stata Registrar	State of Marylan		artment of rtificate o			giene Reg. No. 0 0 5	43812					
1	Physic	ian	1. Decedent's Name (First, Middle, Last)				2. Date of De	ath Day Year	3. Time of Death					
	/Medi			thony		Neal		Decemb	er 31,200	5 6:50AM					
	Exami	ner	4a. Facility Name (If not institution, give				n, or Location of De		4c. County of Deat						
			St. Mary's Ho 5. Social Security Number 6. Se		to and the last at a start of	Leona If Under 1 Ye	rdtown	ra	St. Mai						
	Funeral Director		217-68-7898 15 Usual Residence of Decedent	x 7. Age (In yrs. 50		Months Day		n. Aug.		nplace (State or Foreign untry) ryland					
	fand		10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits					
	Many P-1 sh	ţō	MD St. Ma	ry's Le	exingto	on Park				1 XYes 2 No					
	or 28e	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	untry?					
	ours after death with the Marylar rel', or Items 23a or 28e-1 show Examinat noust be notified at	by Funeral Director	46842 Rogers D	r.			20653		USA						
	lems erro	Iner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of	of Hispanic Origin?	(Specify Yes or No arto Rican, etc.)							
36	s afte	y Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ▼No If Yes, Give		1 ☐ Yes 2 💢 N		,		lack					
9	within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28e-1 show to Medical Examinat must be nullihed at	edt	15. Decedent's Edu	Year or Dates:	162 Doors	dent's Usual Occ									
115	n "ne	plet	(Specify only highest grad	e completed)	(Give	kind of work doi DO NOT use ret	ne during most of w	orking	16b. Kind of Business/l	ndustry					
21215-0036	d with giene	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	:	Skille	d Labor	er	State of	Marvland					
	e file al Hy l'othe vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle,	Maiden Surname)	The grant of					
<u>la</u>	nould be filed within a Mental Hygiene. narked other then natic event, ITE ME	10	Joseph B. Neal				Eli	zabeth I	Locks						
Maryland	2 st and is n		19a. Informant's Name/Relationship (T)		19b. Mailin	g Address (Stre	et and Number or I	Rural Route Numbe	or, City or Town, State, Z.	ip Code)					
	s 1 and 2 f Health item 27		Felicia Buck/				-0440 W	-	ve. Lusby,	MD 20657					
Baltimore,	it of H		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ F	Removal from State	əmətəry, cren	sition (Name of natory or other p		Date	20c. Location - City or T	own, State					
tim	Dept riment of the post of the		* 4 ☐ Donation 5 ☐ Other (Specify)	St			met. 1/		Bryantown						
Ba	permit. Pages 'Department of H Importent: If ite any njury or ot		21. Signature of Toneral Service License	Adams Funeral Home 20605 Aquasco Rd. Aquasco, MD 20608											
			23a. Part1. Enter the disease, or comol shock, or heart failure. List only or	ications that caused the death ne cause on each line.	. Do not ente	er the mode of d	ying, such as cardi	ac or respiratory ar	rest,	Approximate Interval Between					
	Priysician	į v	Immediate Cause (Final disease or condition	a. =	5	aprio	D			Onset and Death					
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):	1 +	open.	2		3 00.43					
		<u></u>	Sequentially list conditions,	Due to (or as a consequ	ence of):	euu	spen.			2 days					
	uted Insit	를	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	240 10 (0) 40 4 00113044	01100 017.					0					
Ć,	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):										
8760,	cate be executed hysician and the burial-transit	cal		i											
		Physician/Medical	IF FEMALE:												
Вох	eath certifi attending I for use as	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnar 1 Live birth 2 ☐ Fetal		Ectopic pregnan	icv		23d. Date of deliv						
0	he he	/sici	1 Yes 2 No	4☐Pregnant at time of de 9☐ Unknown	ath 5	Other (specify)			Month	Day Year					
٥.	that the		Part II. Other significant conditions cor	atributing to death but not resu	fting in the un	iderhing cause o	muon in Part I	220 Did to	bacco use contribute to t	h					
Records,	es be	d by			ing in the di	denying cause g	giveirii Fan I.	236. Did (0	21	pably 4 Unknown					
COL		lete						-							
Re	The law ate has b page 2 s	Completed						24a. Was a autops perfor	y prior to co	opsy findings available impletion of cause of					
_		Ö	25. Was case referred to medical				00 Plans of Pa		2 No 1 □ Yes	2 200					
<u> </u>	S S T	OB	examiner?	ospital: 1 Inpatient 2 🗆 E	R/Outpatient	3 DOA	46	ath (Check only or	ence 6 Other (Special	6.0					
		T:u	27. Manner of Death		28b. Time of Injury	28c. ini			ow injury occurred	y)					
Sion	Attending r death. sctor: After by the funer	atlc	1 Adatural 5 Pending investigation	(Month, Day 18a)	injury		JYes 2 □ No								
		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre	et, factory, office	•	28f. Location (Si	reet and Number or Rura n. State)	al Route Number,					
	urs at urs at orel D			li.				1	,						
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical	29a. Certifier (Check only one) 1	sician: To the best of my knowner: On the basis of examination and manner stated.	rledge, death on and/or invi	occurred at the estigation, in my	time, date and plac opinion, death occ	e, and due to the caured at the time, d	ause(s) and manner as s ate and place, and due to	tated. the cause(s)					
	Withii To to comp	¥	29b. Signature and title of certifier				ise number	2	9d. Date signed (Month,	Day, Year)					
L			Sc Ga	-64 M.I).	1) =	54346		1/2/0	6					
1	0		30. Name and address of person who co	mpleted cause of death (Item					1-1						
(1)	D		Dr. Chandra Saj	ja Post Off	ice B	×640	Hollywoo	od, Maryl	and 20636						
	Sta Registr		JAN 0 5 21	32. Hearstran's Signatu	K A	Cart 3		_							

			1 For State		ryland / Dep				giene	5 1.3013	
			1 - State Registratmend Item # 1. Decedent's Name (First, Middle, Lasi	5,10e&f,15	&19b Per	rificate of 3	1988/b6	JH 2. Date of De	Reg. No.	3. Time of Death	
is.	Physici /Medic		SABINA	RUSHK				Month Decemb	Day	Year 005 9:20 A. M	
1	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Dea		4c. County		
	San San		10921 Citeron (5. Social Security Number 6. Se		(In yrs. last birthday)	N. Poto	omac If Under 24 Hr	s. 8. Date of Bir	Montg	omery 9. Birthplace (State or Foreign	
Ē	Funeral Director			M 2DF	99 Yrs.	Months Days	Hours Mir		1, 1906	Country) New York	
	and w.		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. fnside City Limits	
	Maryli f sho	tor	Maryland Montgome	ery	N. Potor					1X Yes 2 No	
	th the)Irec	10e. Street and Number			10f. Zip Code			10g. Citizen of W		
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show tha Madical Exeminational by milities at	by Funeral Director	10921 Giteron Cou			20870	20878		U. S		
(0	fter de	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No		Was Decedent of H If Yes, specify Cuba	ispanic Origin? (an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	- 14. Race Black	- American Indian, k, White, etc.	
93	ral', o	d by	3 X Widowed 4 □ Divorced	If Yes, Give X Year or Dates:		1 ☐ Yes 2 ☐ XNo	Specify:		Specify:	White	
Maryland 21215-0036	"natu	Completed	15. Decedent's Edi (Specify only highest grad	ication le completed)	(Give	dent's Usuaf Occup kind of work done of DO NOT use retired	during most of w	orking	16b. Kind of Bus	siness/Industry	
212	d within	ошо	Efementary/Secondary (0-12)	College (1-4or 5+	-)	ner	"/		Grocer	V	
nd .	al Hyg	Be C	17. Father's Name (First, Middle, Last)						, Maiden Sumame		
<u>Y</u> a	i Ment Markec	To	Alter Rittner					e Keller			
<u>⊠</u>	id 2 st lith and 27 Is n traun		19a. Informant's Name/Relationship (T) Bennett Rushkoff		n 19b. Maili	Address (Street CITTEON CITCE	an <i>d Number or F</i> Court,	N. Potom	er, City or Town, S nac,Mary	State, Zip Code) Land	
Je,	ss 1 ar	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)						Date	20c. Location - City or Town, State		
Ē	Page ant: If		1 X Burial 2 ☐ Cremation 3 ZXF 4 ☐ Donation 5 ☐ Other (Specify)					2006	S. W. Ra	nches, Florida	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The Marked other than "natural", or items 23a or 28a-f show any injury oceaher traumatic event, the Mardical Exeminer must be natified at once.		21. Signature of Funeral Service Licens	Hottlem	D.	2. Name and Address anzansky– 170 Rockv	ss of Facility Goldberg	g Memoria	ıl Chapel	s, Inc. ryland 20852	
vije vije			23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ications that caused	ne death. Do not ent	er the mode of dyin	g, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Cardiac						Onset and Death	
2	Examiner				consequence of):	11 . 3					
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Diabetes Due to (or as a	- Unconti						
	icate be executed physician and s the burial-transit	Examiner	cause. Chisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
8760,	sician burial	dicai E		Due to (or as a	consequence or):						
9	tificate ng phy: as the	ledic		d							
Вох	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	#F FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. ff yes, outcome o		Ectopic pregnancy				of delivery	
P.O.	that the de	ysic	1 ☐ Yes 2√☐ No 9 ☐ Unknown	4□ Pregnant at ti 9□ Unknown	me of death 5	Other (specify)			Mont	h Day Year	
ري. ص	es that gned by be deta	by Ph	Part II. Other significant conditions co	ntnbuting to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use contrib	oute to the cause of death?	
Vital Records,	w require been sig should b							101	res 2□No 3	B Probably 4 Hunknown	
္တိုင္	e 2 sh	Completed						24a. Was autop	osv pri	ere autopsy findings available for to completion of cause of	
a			25. Was case referred to medical						2 No 1	ath? ☐Yes 2☐ No	
\geq	ysician: is certific director,	To Be	examiner?	lospital:	t 2 ER/Outpatier	t 3 DOA Othe		ath (Check only o	ne) dence 6 🗆 Other	(Casakı)	
Division of	ding Phys h. After this funeral dir		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	28b. Time of	28c. Injury Work	at		now injury occurred		
<u>s</u>	Itendi Jeath. Itor: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆 Y	Yes 2 □ No				
DIV	Hospital or Attending Physician: 44 hours alter death Funeral Director: After this certific tely filled in by the funeral director.	Certification:	4 Homicide determined	building, etc.				City or Tow	vn, State)	or Rural Route Number,	
	To the Hospital within 24 hours a To the Funeral i completely filled	Medicai	29a. Certifier 1 Certifying Physical Control (Check only one) 2 Medical Exemi	sicien: To the best of ner: On the basis of e and manner state	ixamination and/or in	n occurred at the time restigation, in my op	e, date and plac pinion, death occ	e, and due to the ourred at the time,	cause(s) and mani date and place, an	ner as stated. d due to the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	010	0	29c. License			29d. Date signed	(Month, Day, Year)	
	10	-	30. Name and address of person who co	- Jell	Ulan 222) Time		56/88		10/0	-8/05	
			Terrence P. Sheeha	n, M. D. 9	909 Medica	al Center	Drive,	Rockvill	e, Maryl	and 20850	
	Sta Registra		JAN 0 6 2	32. Registrar	s Signature	arts)					

Amend # 29D per Phy. 1-4-06 A.A. Co. Health Dept. PM
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
Amend item#31, perDVR, C851, 1/24/06 TT Department of Health and Mental Hygiene 0 0 5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** Sharon Rizzolo 3¹, 2005 Dec. 2:40 am /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FutureCare Chesapaeake Arnold Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days 1 □ M 212 F Hours Director 55 Yrs 135-40-5132 Dec. 20, 1950 NJ Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be nutified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director Anne Arundel 1 ☐ Yes 2 TNo Severna Park 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 St. Andrews Garth 21146 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 XNo ģ Specify. 3 Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Computer Software 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental Important: If item 27 is marked any Injury or other traumatic evonce. Steve Peters ပ Irene Mate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Peters/Brother 8 St. Andrews Garth Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 2 Jan. Department 4 Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, MD 2006 21. Signature of Funeral Service Livinsee 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park Funeral H Severna Park, MD 21146 Par 1. E ter the disease, or co mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. Physician Sclonsis Pultiple /Medical mediate C. use (Final sease or condition sulting in death) Examiner Physiclan/Medical Examiner death certificate be executed signed by the attending physician and d be detached for use as the buriel-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Due to (or as a consequence of) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown þ page 2 should Completed 24a. Was an autopsy performed? Were autopsy findings available prior to peen completion of cause of death? The law r Director: After this certificate has 1 Tes 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 2 1 ☐ Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral to 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) or A 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted.

| Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d Pate signed (Month, Day, Year) 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 1401 Modeson Park, Clan Burone, 2061 M. NUSAIRED 32 Registrar's Signat State JAN 0 4 2006 Registrar

Amen	ded,10e,		For F.H., TCHD,	12/30/05,sb	aryland	l / Depa <i>Cei</i>	artment of tificate of	Health an <i>Death</i>	d Mental Hy	giene () ()5 43815
	Physicia		1. Decedent's Name (First, Midd	le, Last)					2. Date of De Month	ath	Year 3. Time of Death
	/Medic	al	4a. Facility Name (If not institution	ARTIN PL		_	4h City Town	or Location of D		4c. County	200\$ 6:30a [™]
	Examin	er	15 Curzon C				Easto		eatt)	Tal	
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bir Vin. (Month, Da		Birthplace (State or Foreign Country)
	Director	Į	215-30-4598	1□ X 4 2□ F	72	Yrs.	Months Days	Hours			Baltimore, Md
	and w	}	Usual Residence of Decedent 10a. State 10b. County	/	10c. City,	, Town or Lo	cation				10d. Inside City Limits
	Maryl -f sho	ţŏ	Md Talb	ot	Eas	ston					1 ☐ Yes X No
	within 72 hours after death with the Maryland ene. than "natural", or itams 23s or 28s-f show the Medical Exame as must be codified at	Funeral Director	10e. Street and Number 15	Curzon Court			10f. Zip Code 2160	1		10g. Citizen of V	What Country?
	eath v	erai	11. Marital Status	12. Was Decedent		13 1			? (Specify Yes or No	USA 14 Bac	e - American Indian.
(0	riter dea	F	1 Never Married 2 Mai	rried Armed Forces?		1	f Yes, specify Cut	oan, Mexican, P	uerto Rican, etc.)	Blac	ck, White, etc.
Š	rai', o	β	3 ☐ Widowed 4 ☐ Divorce	IT TAS CIVA	Army		1 □ Yes 2√√ No	Specify:		Specify	White
5-0	be filed within 72 hours ital Hygiene. dother than "natural", event, I'm Medical Ex-	Completed		nt's Education est grade completed)		16a. Deced (Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most of	working	16b. Kind of Bu	usiness/Industry
7	within ene. than	gu	Elementary/Secondary (0-12)	College (1-4or 5	5+)		m Analy			Balti	electric mre Gas &
d 2	s filed withir I Hygiene. other than rent,		12 years 17. Father's Name (First, Middle	Last)		BLOI	III AIIGI		Name (First, Middle,		
Maryland 21215-0036	should be ind Mental I	To Be	Hamlet Newt	on Ruark				Grace	e Elizab	eth An	thony
ar\	d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailin	g Address (Stree	t and Number o	r Rural Route Numb	er, City or Town,	State, Zip Code)
2	of Health itam 27		Virginia E.	Ruark (wif				Ct., E	aston, M		
Baltimore,	Pages 1 nent of H int: if itan		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 □Removal from State	Ce	metery, cren	sition (Name of natory or other pla	· 1	Date		City or Town, State
<u>=</u>	t. Pa rtmen rtant: njury		*4 □ Donation \$ □ Other (3		Ca	-	Cremat		2-31-200	5 Dove:	r, De.
Ba	permit. Page Department of Important: If any injury or once.		P. Cum	1 Henle	w	R	. Carro	oll Hu	rley Fun		
•	Physician /Medical Examiner	-	Immediate Cause (Final disease or condition resulting in death)	t only one cause on each lin	a conseque	ence of):	0	or on the second	PATHY D, SERSE	Hest I de I s	ITU Approximate 3 Interval Between Onset and Death
68760,	ite be nysicia ne bur	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
.O. Box 68	at the death certificate by the attending physicached for use as the t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3 🗆	Ectopic pregnanc Other (specify)	ey		23d. Dat	e of delivery nth Day Year
rds, P	w requires that been signed t should be det	ρ	Part II. Other significant condit	ons contributing to death b	ut not resul	ting in the ur	nderlying cause gi	ven in Part I.	V		ribute to the cause of death? 3 Probably 4 Unknown
Division of Vital Records, P.O.	: The law recate has be	Completed							24a. Was autor perfo 1 ☐ Yes	rmed2 c	Were autopsy findings available prior to completion of cause of death? ☐ Yes 2☐ No
Vits	yaician: Th is certificate director, pag	Be	25. Was case referred to medica examiner?	Hospital:			_ Ot	hor	Death (Check only o		
ŏ	Phys rrthis sral di	5. To	1 Yes 20 No 27. Manner of Death	28a. Date of Inju		R/Outpatien 28b. Time of	t 3 DOA	4 Nursin		dence 6 Other	
ion	nding Phy th. : After thi e funeral	atior	1 Natural 5 Pendi 2 Accident invest	ng (<i>Month, D</i> aj igation	y Year)	Injury		rk?]Yes 2∐No			
Divis	i Dife	ertification;	3 Suicide 6 Could 4 Homicide deter	not be nined 28e. Place of Injuding, etc	ury - At hon c. (Specify)	ne, farm, stre	et, factory, office		28f. Location (5 City or Tov		er or Rural Route Number,
]	Hospita 4 hours Funeral	edical Ce	29a. Certifier (Check only one) 2 Madica	ng Physician: To the best Examiner: On the basis of and manner sta	f examination	rledge, death on and/or inv	occurred at the trestigation, in my	ime, date and pl opinion, death o	ace, and due to the occurred at the time,	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certific	The L	ZIN	10	29c. Licen	se number 2396		29d. Date signed	9. 05
(.	1	-	30. Name and address of person	who completed cause of d	leath (Item :	23a) (Type. i					
1/	3+1VA)		Scott D. F	riedman. M				Ave. Ea	aston, M	d2160	01
(Sta Registra		31. Date filed (Month, Day, Year	32. Registra	ar's Signatu	ire					
-				Sales and the sales and the sales are sales and the sales are sale		A PROPERTY AND AND	A COLUMN TO THE PARTY OF THE PA				

			1 - For State Registrar	State of M	aryland / De	partment of ertificate o	Health a	and Ment	al Hygie Reg.	Or C3 C3	43816				
			1. Decedent's Name (First, Middle,	Last)				2. Da	ate of Death	140.	3. Time of Death				
	Physic		Michael David	Doul Come				1		Day Year	8:43 ^A				
	/Medi Examii		4a. Facility Name (If not institution,			4b. City. Town	, or Location o		cember	26 2005 4c. County of Death	0:43				
	LAGITIII	101													
	Funeral		1957 La Pointe 5. Social Security Number		e (In yrs. last birthda		Spring ar If Under		ate of Birth	Mont gome	ry place (State or Foreign				
	Director		450-35-0475	1 ∑ M 2□ F	30 Yrs	Months Day	s Hours	Min. (M No	fonth, Day, Ye	ar) Cou	ntry)				
			Usual Residence of Decedent					INO	V. 20,	19/5) Te	xas				
	show		10a. State 10b. County		10c. City, Town or	Location				1	0d. Inside City Limits				
	Ma-f	Ş	MD Montg	omery	Silver	Spring					No Yes 2 □ No				
	h the	<u>e</u>	10e. Street and Number			10f. Zip Code)		10g.	Citizen of What Cour	ntry?				
	th wil	a	1957 La Pointe	Dr.		2090	02			USA					
	ours after death with the Maryla raf', or Itams 23a or 28a-f shov Examinational Committed at	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 1	3. Was Decedent o	f Hispanic Orio	in? (Specify Y	es or No-	14. Race - Americ	an Indian,				
9	or Ite	2	1 ☐ Never Married 2 🔀 Married			If Yes, specify Co		, Puerto Rican,	etc.)	Black, White,					
8	ours Fer	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1□Yes 2⊡ूN	lo Specify:			Specify: Whi	te				
21215-0036	d within 72 hours after death with the Maryland Jiene. r than "natural", or Itams 23a or 28a-f show the Medical Exament must be indiffied at	Completed	15. Decedent's (Specify only highest		16a. De	cedent's Usual Occ	supation	of working	16b	Kind of Business/In-	dustry				
21	ithin De.	du	Elementary/Secondary (0-12)	College (1-4or	0+)	ve kind of work dor DO NOT use reti		di tronting	TTO						
S	- A	ပွဲ	12	2	Mili	tary Poli				Army					
<u>n</u>	d tal	Be	17. Father's Name (First, Middle, La	ist)			18. Mother	r's Name (First	, Middle, Maid	len Sumame)					
yla	ould be Mental Parked c	2	David Harold Ch					ara Som							
Maryland	and and		19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	illing Address (Stre	et and Number	r or Rural Rout	e Number, Cit	y or Town, State, Zip	Code)				
	is 1 and 2 should of Health and Mer item 27 is marke other traumatic		Ladonna J. Some	rs-Wife	1957	La Point	e Dr. :	Silver	Spring	MD 20902					
Baltimore,	of H of H if ita		20a. Method of Disposition 1 Burial 2 □ Cremation 3	□ Pemoval from State	20b. Place of Dis	position (Name of rematory or other p	lace)	Date	20c.	Location - City or To	wn, State				
Ē	permit. Pages Department of I Important: If ite any injury or of once.		`4 □Donation 5 □ Other (Spe		Arlingt	on Nation	al 📋	1/6/06	Ar	lington, V	7A				
alt	permit. Depart Import any inj once.		21. Signature of Forecal Service Lic	ensee)	22. Name and Add	roes of Facility								
<u> </u>	89 E 29	1 !!!	- Call	22. Name and Address of Facility Murphy Funeral Home 4510 Wilson Blvd. Arlington VA 22203											
			23a. Part1. Enter the disease, or co	omplications that caused	the death. Do not e	enter the mode of d	ying, such as c	ardiac or respi	ratory arrest,	10 2220	Approximate Interval Between				
	Physician	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Peripheral Nerve Sheath Tumor									Onset and Death				
	/Medical		resulting in death)	Due to (or as	a consequence of):										
	Examiner		Conventingly, liet and distance	Neurof:	ibromitosi	.s									
	n =	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Dus to (or as	à consequence of.										
	nd nd trans	ami	Cause (Disease or injury that initiated events	c											
Ó,	e exe ian a urial-	Ĕ	resulting in death) Last	Due to (or as	a consequence of):										
8760,	cate be executed physician and the burial-transit	dlcal		d											
	as as		IF FEMALE:		_					- 4,1					
Вох	death certific e attending p	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth		☐Ectopic pregnan	cv		11	23d. Date of delive	-				
<u>.</u>		by Physiclan/Me	1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐Unknown		Other (specify)				Month	Day Year				
P.O.	at th	Phy	9 Unknown												
Ś	se ded		Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause g	iven in Part I.	23		use contribute to th					
ord	w requir been si should	ted				· · · · · · · · · · · · · · · · · · ·		[1 🗌 Yes	2 ☐ No 3 ☐ Proba	ably 4 X Unknown				
Vital Record	elawr hasbe je 2sh	Completed						24	a. Was an autopsy	24b. Were autop	sy findings available apletion of cause of				
		No.						10	performed? Yes 2011	death?					
ita	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?				26. Place of	of Death (Chec							
	hysic his ce I dire	2	1 ☐ Yes 2 ☐XNo	Hospital:	nt 2 ☐ ER/Outpati	ent 3 DOA	ther: 4 🗆 Nurs	sing Home 5	Residence	6 ☐Other (Specify)				
Division of	ding Phy h. After thi funeral (27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time (Year) Injury	of 28c. Inju			scribe how in						
<u></u>	Attanding r death. ector: After by the fune	atle	2 Accident investigat	ion			Yes 2 □ N	0							
≝	or Attan after deat Director: in by the	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place of Inju	ury - At home, farm, s	street, factory, office	9	28f. Loc	cation (Street a	and Number or Rural	Route Number,				
Ω .	ital c irs af ral Di led ir		-							•					
	To the Hospital or Attan within 24 hours after deat To the Funeral Director: completely filled in by the	edical	(Orlock Orly) Z I Medical Ex	Physician: To the best of aminer: On the basis of	of my knowledge, dea	ath occurred at the	time, date and	place, and due	to the cause	s) and manner as sta	ited.				
	To the H within 24 To the F complete	led	- A +	and manner sta	ted.			Joodined at th							
i	To Con	Σ	29b. Signature and little of certifier	/			ise number			ate signed (Month, D	ay, Year)				
						3	allo (Wis	Cunsin)	01/	05/2006					
	2		17	o completed cause of de	eath (Item 23a) (Type	Print)									
			Jeffrey Jackso		eorgia Ave	.NW Wash:	ington,	DC 203	307						
	Sta		31. Date filed (Month, Day, Year)	2. Registra	ur's Signature	use o		· 							
	Registra	31	JAN 0 6 200	10 Alexan	JO AGE										

				State of Marylar	nd / Depa	artment of I	Health and	-	_	
			1 - State Registrar		Cei	tificate of	Death	Reg	. No. U U	43817
200	Physic /Medi		1. Decedent's Name (First, Middle, Last James Edward Sh					2. Date of Death Month Decembe	r ^{Day} 31,2 ^Y	3. Time of Death 2:00p. M
Transfer Co	Examii		4a. Facility Name (If not institution, give Charles County Nu			4b. City, Town, o	or Location of Dea	th	4c. County of Charl	
	Funeral Director		5. Social Security Number 6. Se		last birthday) Yrs.	If Under 1 Year Months Days			ear)	Birthplace (State or Foreign Country) ennsylvania
	Maryland f show	or	10a. State 10b. County Maryland Charles		y, Town or Lo LaPlata					10d. Inside City Limits 1 ☐ Yes 2 XNo
	or 28a	Director	10e. Street and Number		Jar Taca	10f. Zip Code		100	. Citizen of Wha	
	s 23a	ra	6376 Nelson Road			206			U.S.A.	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show appringly or other traumatic event, ite Modical Examination multiple and once.	Completed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces?1 MYes 2 □ No If Yes, Give Year or Dates:	l l	Vas Decedent of t f Yes, specify Cub ☐ Yes 2∑ No		Specify Yes or No- rto Rican, etc.)	Black, V	American Indian, Vhite, etc. White
21215-0036	thin 72 ho e. an "natur Medical	pieted	15. Decedent's Edd (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	16a. Deced (Give life. L	ent's Usual Occup kind of work done OO NOT use retire	pation during most of wo d)	orking 16	b. Kind of Busin	ess/Industry
2	ed wi	Co	10		Refr	ig & A/C	Mechani	.c U.	S. Gove	rnment
Maryland	be fill	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, Ma		
<u> </u>	hould d Mer marke maric	2	James E. Shaffer, 19a. Informant's Name/Relationship (Ty					lberta Var		
	land 2 s lealth an m 27 ls r		Ellen Shaffer	Wife	6376	Nelson		ural Route Number, C Plata, Md.		e, Zip Code)
Baltimore,	Pages 1 Thent of H ant: If ita ury or ot		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	lemoval from State Tr:	Place of Disposementery, creminately Manager Manager Manager Manager Manager Manager Manager Manager Manager M Manager Manager br>Manager Manager	sition (Name of eatory or other place lemorial	Jan. 5 Gardens	5, 2006 Wa	aldorf.	or Town, State Maryland
Balt	permit. Departimport any inj		21. Signature of Funeral Service Licens	M00668	Wi	Name and Addre	ss of Facility Uneral H	Iome, P.A. Id, Indian		
,160,	Physician /Medical Examiner be executed burial-transit superprise the private state of the pr	ilcal Examiner	23a. Part1. Enter the disease, or complishock, or hear facture. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each line.	uence of):		Demen	•		Approximate Interval Between Onset and Death
O. Box 68	The law requires that the death certifica te has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnal 1□Live birth 2□Fetal 4□Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of Month	delivery Day Year
ds, P	w requires that s been signed by should be deta	þ	Part II. Other significant conditions con		1		en in Part I.			e to the cause of death? Probably 4 QUnknown
Hecord	s beer shou	jete	Carebra V.	lia (info		0		24a. Was an		autopsy findings available
	10	e Completed	25. Was case referred to medical	22.20-20. 192	LI BE EL			autopsy performed 1 Yes 2	? prior death	to completion of cause of
>	Physician: this certific ral director,	0 8	examiner?	ospital:	ER/Outpatient	3 DOA Oth		ath (Check only one)	. 55	
	fler	Itlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun	4 Mary and Sing to	ome 5 Residence 28d Describe how		pecify)
DIVISION	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify,	me, farm, stre			28f. Location (Stree City or Town, S	and Number or late)	Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edicai	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sicien: To the best of my knowner: On the basis of examination and manner stated.	wledge, death ion and/or inve	occurred at the timestigation, in my op	ne, date and place pinion, death occu	, and due to the caus rred at the time, date	e(s) and manner and place, and c	as stated. lue to the cause(s)
)	Vith Com	×	29b. Signature and title of certifier (All in the All	Jagour in	D	29c. License		29d. 3 /	Date signed (Mo	**
9	Prel		30. Name and address of person who co							
4	りりす Sta	10	31. Date filed (Month, Day, Year)	mpleted cause of death (Item 2 2 2 32. Registrar's Signate	un p	luta	21)	2064	5	
	Registra		JAN 0 6 2	006 Marie Signati	J. 19	partie				

	for State Registrar	State of Maryla		rtment of tificate of		and Mer		ene g. No.	005	43818
Physician /Medical Examiner	Decedent's Name (First, Middle, Herbert Branz) Harbert Branz) 4a. Facility Name (If not institution, grans) FORT WASHINGTON	Stanfield ive street and number)	R		VASHING	Dif Death	Date of Death Month ECEMBEI	R 29,	unty of Death	3. Time of Death 6:39 P
Funeral Director	231-58-2382	Sex 7. Age (In yrs 5)		If Under 1 Yea Months Days		Min. Au	Date of Birth (Month, Day)	γ _θ 4]94	9. Birth V11	place (State or Foreigntry). :ginia
or 28e-f ehow	Usual Residence of Decedent 10a. State 10b. County MD Prince 10e. Street and Number		ity, Town or Loo on Hil				10	g. Citizer	of What Cou	10d. Inside City Limit 1 AYes 2 □ N
er death wittems 23s har count to	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U		2074.	Hispanic Orig ban, Mexican,	gin? (Specify , Puerto Rica			Race - Ameri Black, White, ecify: Bla	etc.
ed within ygiene. ser then " t, the Wes	15. Decedent's (Specify only highest stemmentary/Secondary (0-12) 12	rade completed) College (1-4or 5+)	(Give k	ent's Usual Occi kind of work doni O NOT use retir Cutte:	during most ed)			elec		dustry nications
should be fill and Mental H marked oth umatic even	Elislia Stanf:	leld	10h Mailin	a Address (Street	Sus	ie Le	e You	nger	:	- Code)
vermit. Pages 1 end 2 sl Department of Health and mportent: If item 27 is r nny injury or other treur 2008.	Deborah K. Sta	anfield/Wife	1307	G Address (Street Crisf:	ield I	Dr. 0	xon H	ill,	MD 2	20745
Pages 1 ment of F ant: If ite ury or ot	20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	Removal from State		atory or other pl		Date 01/12			ion - City or T 1gton,	own, State Virginia
permit. Departi Import eny Inj once.	21. Signature of Funeral Service Lic	reene J.								, INC. 22314
bhysician and whisician and the burial-transit the	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to this educate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect of the total or as a consect or as a consect of the total or as a consect of the total or as a consect of the total or as a consect of the total or as a consect or as a consect of the total or as a consect or as a consec	quence of):	(ances						
es that the death certificate gned by the ettending phys be detached for use as the by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 □l	Ectopic pregnand Other (specify)	су			23d.	Date of deliv Month	ery Day Year
	Part II. Other significant conditions	contributing to death but not re-	sulting in the un	derlying cause g	iven in Part I.				contribute to t	he cause of death?
The ete his page	25. Was case referred to medical							ZNo	4b. Were auto prior to co death? 1 \(\sum \text{Yes}	ppsy findings availabl mpletion of cause of 2 No
Phyeiclen: this certific rel director. To Be (examiner? 1 X Yes 2 □ No		ER/Outpatient	3L DOA	ther: 4 🗆 Nur		sck only one 5 ☐ Residen		Other (Specif	·y)
ding h. After fune	27. Manner of Death 1	be On Blace of lainer At h	28b. Time of Injury		Yes 2 N	No 28f.	Describe how Location (Stre City or Town,	et and N		al Route Number,
To the Hospital or Attenwithin 24 hours after deat to the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier 1 ☐ Certifying	Physician: To the best of my kn	owledge, death	occurred at the	ime, date and	d place, and	due to the cau	ise(s) and	d manner as s	tated.
To the H within 24 To the F complete	29b. Signature and title of certifier John Sy	and manner stated.			se number	Journal a	290	d. Date si	gned (Month,	Day, Year)
State Registrar	30. Name and address of erson what is a second of the seco	lenberg M. 1 22. Registrar's Sign) 1	Print) 111 PENN	STREE	ET, BAI	TIMORE	E, MA	RYLAND	, 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Four Park Property Proper Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) NATTIE SHAPTRO 2. Date of Death 3. Time of Death **Physician** Day 7:30+ DECEMBER 30, 2005 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 M 2 XF Months Director 004-22-0662 81 10/09/1924 MAINE Usual Residence of Decedent death with the Maryland 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, its Mudical Examiner must be notified at MARYLAND MONTGOMERY Director ROCKVILLE 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6105 MONTROSE ROAD #4112 EAST Funeral 20852 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Menial Hygiene. Innst of Health and Menial Hygiene. Int: If Item 27 Is marked other than "natural", or Itel 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 SECRETARIAL WORK GOVERNMENT 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) SAMUEL WISE 0 SARAH LELANSKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnne MILLER/DAUGHTER 5441 WOLF RIVER LANE, COLUMBIA, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of the Important: If Ite any injury or of once. ty Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) LEBANON CEMETERY 01/03/2006 ADELPHI, MARYLAND 21. Signature of Funeral 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death P.O. 5 Other (specify) 1 ☐ Yes 2 No the 9 Unknown 9 Unknown É Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 Completed 3 □ Probably 4 Nunknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death Director: / 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral [12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier icai (Check only one) To the the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 29c. License number DECEMBER 31, 2009 Handone 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print). POAD, ROCKVILLE, MD 20852 ARBITRAKALAZNY M.D. 6121 HUNTRE

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

JAN 06

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 0 0 5 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) DECEMBER 30, **Physician** 2005 Florence 8:25A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** MONTGOMERY 3701 INTERNATIONAL DRIVE #401 SILVER SPRING 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 07/03/1911 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** NEW JERSEY 1□M 2QF 091-10-2734 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-1 show Items 23e or 28a-f show 1X Yes 2 □ No Directo SILVER SPRING MARYLAND MONTGOMERY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 U.S.A. 3701 INTERNATIONAL DRIVE #401 death v Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) nit. Pages 1 and 2 should be filed within 72 hours after eartment of Health and Mental Hygiene.
ortant: If Item 27 is marked other then "neturel", or Ite intry of other traumatic event, the Medical Exertiting in the Medical Exertition in the Medical Ex ☐Yes 2 No fYes, Give 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: δ 3 X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) CELIA GREENSTEIN SAMUEL KAPLAN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 11825 TRAIL RIDGE DR, POTOMAC, MARYLAND MARGARET HADLEY/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury of once. FALLS CHURCH, VIRGINIA NATIONAL CREMATORIUM 01/20/2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Cance disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No should been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy perform 2 No certificate 1 ☐ Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide within 24 hours a To the Funeral E 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicef Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 12/30/05 D47928 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3701 INTERNATIONAL DRIVE, SILVER SPRING, MARYLAND DR. LILA BAHADORI, 32 Registrar's Signature 31. Date filed (Month, Day, Year) State **JAN 06** Registrar

	1	state Registrar	State of Maryland	Ce	tificate of L	Death			000	43821
ysiciar		Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
/ledica	1	Regina Elizabe			4b. City, Town, or	Location of Doct	Dec.	2.2	2005 County of Deeth	4:05 P M
amine	r	4a. Facility Name (If not institution, give s			Centrev		11		een Ann	
orol		Corsica Hills No. 5. Social Security Number 6. Sex		ast birthday)	If Under 1 Year	If Under 24 Hrs				place (State or Foreign Intry)
eral ctor			IM 20 F 70	Yrs.	Months Days	Hours Min.	Sept. 2	1935		ware
	-	Usuel Residence of Decedent								10d Inside City Limits
5		10a. State 10b. County	10c. City	r, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
any injury or other traumatic event, the Medical Examinar must be notition at ances. To De Commissed by Europea Directors	. –		nnes	Graso	nville			10- 0%		
2 à	5	10e. Street and Number			10f. Zip Code				en of What Cou	шиуг
0.0	e a	141 Watkins Road	12. Was Decedent Ever in U.	S 13	21617 Was Decedent of Hi	spanic Origin? (S	Specify Yes or No	USA - 1	4. Race - Amer	ican Indian,
1	runeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No		Il Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)		Black, White	, etc.
1	2	3 Widowed 4 Divorced	If Yes, Give 'Year or Dates:		1 ☐ Yes 2 🂢 No	Specify:		3	Specify: B1	ack
100	Completed	15. Decedent's Edu (Specify only highest grade		16a. Dece	dent's Usual Occupa	ation during most of wo	rking	16b. Kind	d of Business/I	ndustry
1 2 2	d	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	•			
		17. Father's Name (First, Middle, Last)	4	Ch	ef	18 Mother's Na	me (First, Middle			ds Asst. Lva
a	ă		D., 1. 1. 1.					, 1812/0011	, om 200	
F	0	James 19a. Informant's Name/Relationship (Ty.	Brinkle	-	ng Address (Street a		Lewis	er City or	Town State Z	in Code)
		Shonte Carpenter	•		W. Sunse					
	1	20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of		Date		ation - City or T	
		1 Burial 2 Cremation 3 R 1 Donation 5 Other (Specify)	emoval from State RC	obinso	matory or other place BS AME	1	0 2005	Carco	00024110	Maryland
	Ť	21 Signature of Fun rat Service License		nurch	2. Name and Address	s of Facility				Lett y Latin
once		The sail			Bennie S 426 Dove	mith Fun	eral Ho	ue n. Kar	vlaná 2	1601
	1	23a. Part1. Exter the disease, or complishock, or leart failure. List only or	cations that caused the death	n. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory a	rrest,	, 200 5 5 7 5 7 5	Approximate Interval Between
an		Immediate Cause (Final	Subfolin	u as	d uncas	Kernier	ion			Onset and Death
al		disease or condition resulting in death)	Due to (of as a consequ		,			1/		100
er		Conventially list conditions	Subdure	Ken	nom	\cap	20/	NY MEDICAL	EXAMINER	days
100	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	1		The state	ATION APPROVED	D1		//
8	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	/ /	ma	CERTIFIC				months
ů	<u> </u>	resulting in death, cast			-small	lune ca	mian.		1	marine the
100	dical		Main spain	Pipe	-9/11/00 /	ung in	ricev	1125		7/1/07
	മ -	IF FEMALE:	3c. If yes, outcome of pregna	ncv				25	3d. Date of deliv	VALV
100	Pnysician/M	in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)				Month	Day Year
19) ASI	1 ☐ Yes 2. No 9 ☐ Unknown	9 Unknown		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
	Dy Pr	Part II. Other significant conditions cor	atributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
							10	Yes 2□	No 3□Pro	babiy 4 Unknown
100	Completed						24a. Was		24b. Were aut	topsy findings available ompletion of cause of
8	E						auto perf	ormed?	death?	2 No
	O	25. Was case referred to medical				26. Place of De	ath (Check only	-		
	0	examiner?	lospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Othe	er: 4 Nursing I	Home 5 ☐ Res	idence 6	☐Other (Spec	ufy)
		27. Manner of Death 1/5 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	Worl	at k?	28d. Describe			
190	atic	2X Accident investigation	12/18/2005	Unknow	7 n M 1□	Yes 2 XNo	subjec			
19:4	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, larm, str	eet, lactory, office		City or To	wn State		rai Route Number,
			at hom							asonville,
3	dical	(Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examinat							Stated.
- 1.3	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number		29d. Date	signed (Month	, Day, Year)
		and the second s	111111		77	75950	5	1	Z. 28-	05
		30. Name and address of person who co	mplated course hi death //	23a\ /T.:a-	Print					
		11. 1 170	18 8000	610 /	Print) Dutema	enc/ in	e E-asq	on	MD Z	1601
State	e .	31. Date filed (Month, Day, Year)	32. Registrar's Signa		- water ap	and Color	1			
- State	e Ir		32. Registrar's Signa	ture	1 4					

			For State	State of M	aryland /		artment of F				ene 005	43822
			Registrar Decedent's Name (First, Middle, Last	1)			11110010 01	- Cutti		Date of Death		3. Time of Death
	Physici	an	Maria	,	Schenk				D	Month ecember	Day Year 200	
	/Medic		4a. Facility Name (If not institution, give	street and number			4b. City, Town, o	r Location o		ecember	4c. County of De	
	Examin	er	Genesis Eldercar						51 DO L 01			
			5. Social Security Number 6. Se		ge (In yrs. last	birthdav)	Annapol If Under 1 Year		24 Hrs. 8.	Date of Birth	Anne Aru	inthplace (State or Foreign
	Funeral Director			_M 2 XX	96	Yrs.	Months Days	Hours	Min.	(Month, Day, '	Year) (ch Republic
			Usual Residence of Decedent							0 . 12,	1707 020	си керивіте
	yland ***		10a. State 10b. County		10c. City, To	own or Lo	cation					10d. Inside City Limits
	Man	to	MD Anne Aru	nde1	Crof	ton						1 ☐ Yes 2XXNo
	r 28s	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of What (Country?
	3a o	D	1810 Whites Ferry	Place			21114				USA	
	deati	Funeral	11. Marital Status	12 Was Decedent	Ever in U.S.	13. \	Was Decedent of H	lispanic Orig	gin? (Specify	y Yes or No-	14. Race - An	
9	after or Its	Ē	1 Never Married 2 Married	Armed Forces 1 ☐ Yes 200 If Yes, Give	No	1	I □ Yes 2 X No	Specify:		an, etc.)	Black, Wh	White
ဗ္ဗ	ral',	l by	X Widowed 4 □ Divorced	Year or Dates:			200100	эрвспу.			Specify:	MILLE
2	72 h natu dical	Completed	15. Decedent's Edu (Specify only highest grad		11	6a. Deced (Give	lent's Usual Occup kind of work done OO NOT use retired	ation during most	t of working	1-	6b. Kind of Busines	s/Industry
7	ithin	du	Elementary/Secondary (0-12)	College (1-4or	5+)			d) -				
2	od w ygier t, th	Col				Homen	naker	40.11.1	1 51 75		wn Home	
ב	be fill d off	Be	17. Father's Name (First, Middle, Last)								aiden Surname)	
<u> </u>	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Iteme 23a or 28e-1 ehow aumatic event, the Medical Examiner must be notilled at	2	Joseph Ticha	===:	1.		1			otilda		7 - 11
Maryland 21215-0036	2 sh and le m		19a. Informant's Name/Relationship (T)				,				City or Town, State	
ó	end lealth im 27 her t	1	Harry J. Schenk (Son)					Place		on, MD 21	
0	ges 1 t of t if ite	113	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F	Removal from State	ceme	etery, cren	sition (Name of natory or other plac	i			oc. Location - City c	i Town, State
altimore,	men tant: lury		4 □ Donation 5 □ Other (Specify)		Lake		Mem. Gdn		1/4/20	006 D	avidsonvi	.11e, MD
ga Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important; if Item 27 is marked eny Injury or other traumatic evonce.		21. Signature of Funeral Service Licens	99		22	Name and Addre Hardesty	ss of Facility Fune	ral Ho	ome. P.	Α.	
	40200		70 0		daha dasah F		12 Ridge	ly Av	enue.	Annapo	lis. MD 2	1401 Approximate
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ne cause on each	ine.	o not enti	ar the mode or dylr	ig, such as	Cardiac or re	espiratory arres	st,	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Ore browns undary distance Due to (or as a consequence of):									
	/Medical Examiner		resulting in death)	•								
			Sequentially list conditions,	b. Description	E it nor sections	na afte						
	bed islt	lne	Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury	200 10 101 31	FIELD HOUSE CHOICE	00 017.						
	and and II-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequent	ce of):						
8760,	The law requires thet the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	alE			1							
387	phys phys s the	dical		d								
×	certif ding Ise e	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy						23d. Date of d	elivery
Box	eath certific attending p I for use es	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1□Live birth 4□Pregnant a			Ectopic pregnancy Other (specify)	<u> </u>			Month	Day Year
o.	by the de	ysk	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown			- (-,,,,, -					
۵.	res thet igned b be deta	4	Part II. Other significant conditions co	ntributing to death	but not resultin	g in the ur	nderlying cause grv	en in Part I.		23e. Did toba	icco use contribute	to the cause of death?
gp	uires sign	d by							Programme and the state of the	1 🗌 Yes	2 D\$ANo 3 □ F	Probably 4 Unknown
Ö	w requ been shoule	lete								24a. Was an	24b. Were a	autopsy findings available
He e	The lav	Completed								autopsy perform	ed? death?	
Division of Vital Records,	iclen: Th certificate rector, pag		25. Man ages referred to modical					00 Bl	-4 045	1 ☐ Yes 2		s 2000
5	Physiclen: r this certifice ral director, i	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpati	ont 20 CD	Outpatien	t 3 DOA Oth	or		heck only one	ce 6 ∐Other (Sp	
ō	Phy r this	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Inju	ury 281	b. Time of					injury occurred	өспу)
o	ding th: Afte	ţ	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ay Year)	Injury		k? Yes 2∐1	No			
<u> S</u>	I or Attending P efter death. Director: After t	flca	3 Suicide 6 Could not be	288. Place of In	jury - At home	, farm, stre	et, factory, office		28f.			Rural Route Number,
á	ellor Direction	Certification;	4 Homicide	building, e	tc." (Specify)					City or Town,	State)	
	To the Hospital or A within 24 hours efter To the Funeral Direcompletely filled in by		20a Certifying Phy (Check only 2 Medical Exam	reician: To the best	of my knowled	dge death	occurred at the tir	ne date an	d place, and	due to the cal	isa(e) and mannar :	as stated.
	the H in 24 the Fi	Medical	one)	and manner s	tated.	and/or inv			un occurred i			
	Veith To 1	Σ	29b. Signature and title of certifier				29c. Licens	e number		290	d. Date signed (Moi	nth, Day, Year)
			· WW	WD			1) 38	755		/	13/06	
			30. Name and address of person who c	ompleted cause of	death (Item 23	а) (Туре.						
		4	Jatjeet Singh Si	Mry 208	Crain	High	way 54	2 04	Pin Bu	mu 1	AD 21061	
	Sta		31. Date filed (Month, Day Year)		rar's Signature	0	V					
	Registr	ar	JAN 0 4 200	6 The	V St	100						

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Vear Physician Leroy T. Snowdon December 31, 2005 5:07 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ginger Cove Health Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Hours 1**√**M 2□F Days Yrs Director 007-18-7803 91 Nov. 8, 1914 Maine Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show other traumatic event, the Mudical Examiner must be notified at 1 Yes 2 No Anne Arundel Annapolis Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with to nent of Heatth and Mental Hygiene.
ant: if item 27 is marked other then "natural", or items 23s or? 5310 River Crescent Drive 21401 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? SYes 2 No Yes. Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: Specify: White 3√√Vidowed 4 ☐ Divorced Year or Dates: WW II 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Governmental Elementary/Secondary (0-12) College (1-4or 5+) Association Executive 4 Relations 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Snowdon Olga Olsson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles Snowdon/son 25 Crestview Drive Madison, Connecticut 06443 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: if eny injury or once. 4 □ Donation 5 □ Other (Specify) Baltimore Crematory | 1/5/2006 Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of End Stug Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Yo
9 Unknown Month Year ó Day 4 Pregnant at time of death 5 Other (specify) P.O. F sate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II, Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes Hospitel or Attending Physicien: After this certification funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: Certification: To 1 ☐ Yes 2 🗔 № 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death A Natural 2 ☐ Accident 5 Pending Japiter .
4 hours after dec.
--rei Director: After 1 TYes 2 🗌 No investigation 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Fo the within 24 hours are.
To the Funerel Director of 29a. Certifier Extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of pers of death (Item 23a) (Type, Print) OUX 31. Date filed (Month, Day, Year) JAN 0 4 2006 Registrar

		l	For Stete Registrar	State of Ma	ryland / [Department of Certificate of	Health and I	Mental Hy	•	43824
	00		1. Decedent's Name (First, Middle, La					2. Date of Dea	ath Day Ye <i>a</i> r	3. Time of Death
	Physici /Medic		effic hi	nda Su	Hiver)		12	10 200	5 345 am
	Examin		4a. Facility Name (If not institution, give	ve street and number)		4b. City, Town,	or Location of Deatl	1	4c. County of Dea	ith
				rsons Assi			isbury	/	Wico	mico
п	Funeral			1 □ M 25 □ F	(In yrs. last bir	thda If Under 1 Year Months Days		8. Date of Birt (Month, Da	y, Year) 9. Bi	rthplace (State or Foreign ountry)
	Director		219-05-8868 Usual Residence of Decedent	85	5	115.		9/27/1	920 M	aryland
	land bw		10a. State 10b. County		10c. City, Town	n or Location				10d. Inside City Limits
	Mary fish	to	Maryland Wicomi	co	Sali	isbury				1 X Yes 2 ☐ No
	r 286	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	h with	by Funeral Director	1017 Tyler Aven	ue		218	304		USA	
	deat	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decedent of	Hispanic Origin? (S oan, Mexican, Puert	pecify Yes or No-	14. Race - Am Black, Wh	
92	or Its	,Fu	1 Never Married 2 Married	1 Tes 2 XN	lo	1 ☐ Yes 2 🕱 No				
21215-0036	within 72 hours after death with the Maryland ene. Than "neturel", or llems 23a or 28e-f show ha Medical Examirar must be multibud at	d b	3 XWidowed 4 Divorced	Year or Dates:	1					white
15-	"nat	Completed	15. Decedent's E (Specify only highest gr	ade completed)	16a.	 Decedent's Usual Occu (Give kind of work done life. DO NOT use retire 	pation a during most of wor ad)	rking	16b. Kind of Busines:	s/Industry
12	withi ene. than	шc	Elementary/Secondary (0-12)	College (1-4or 5		Homemaker	,,,		Domestic	
d 2	filed Hyg other ent, I	Ö	17. Father's Name (First, Middle, Las.	r)	-		18. Mother's Nar	ne (First, Middle,	Maiden Sumame)	
Maryland	2 should be filed with and Mental Hygiene. Is marked other than eumatic event, than	To Be	Rockwood Finley	Coleman			Effie	Covey		
ary	shou and N s mai	-	19a. Informant's Name/Relationship		19b	. Mailing Address (Stree				
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if the Marylan Item 27 is marked other than "naturel", or items 23a or 28e-f show other treumatic event. I'm Nedical Examinar must be notified at		James M. Sulliva	n Jr/son		425 Valley		Salisbu	ry, MD 218	04
ore	of He of Her		20a. Method of Disposition 1	Romoval from State	20b. Place of cemeter	f Disposition (Name of ry, crematory or other pla	асе)	Date	20c. Location - City o	Town, State
Ĕ	Pag nent ant: I		'4 □Donation 5 □Other (Speci		Wicom Park	nico Memoria	al 12/	14/05	Salisbur	y, MD
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Lice	repres (KIP	Adlioway 501 Snow	Funeral Hill Rd.	Home Pro , Salisb	fessional ury, MD 21	Association 304
г			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused one cause on each lin	the death. Do r	not enter the mode of dy	ing, such as cardiad	or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		A	swo				54cars ·
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):				
н	LXdiimici	<u>.</u>	Sequentially list conditions,	b. — Due to /or an o		of):				
	led isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence	O().				
	xecul and al-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as a	a consequence	of):				
68760	death certificate be executed e attending physician and of for use as the burial-transit	ical	· ·	d						
89	ficate p phy s the		3	d						
Вох	n cert	D/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		0.75			23d. Date of de	Hivery
-	0 0	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at		3 □Ectopic pregnand 5 □ Other (specify)	;y 		Month	Day Year
P.0.	at the by th	Physiclan/Med	9 Unknown	9□ Unknown						
	The faw requires that the death cer sie has been signed by the attendir page 2 should be detached for use	ξ	Part II. Other significant conditions	contributing to death bu	it not resulting in	n the underlying cause g	ven in Part I.		obacco use contribute t	
ord	w requir been si should	ted						1 🗆 Y	res 2.27No 3P	robably 4 Unknown
Records,	has be	Completed						24a. Was autop	sy prior to	utopsy findings available completion of cause of
<u>=</u>	The	Cou							rmed? death? 2 No 1 ☐ Ye	2 □ No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospitale				ith (Check only o	ne)	
of	Physi this o	2	1 Yes 2 No			Thatlett 3000			tence 6 Other (Spe	ecify) JBP .
	ding F	lon	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 280.	Time of 28c. Injury Wo	ork?]Yes 2 □No	28d. Describe r	now injury occurred	
isio	l or Attending after death. Director: After in by the fune	icat	2 Accident investigation 3 Suicide 6 Could not to		ry - At home fa			28f Location /5	Street and Number or F	ural Route Number
Division	lor A after Direction by	Certification:	4 Homicide determined	building, etc	. (Specify)	arm, street, factory, office		City or Tow	vn, State)	arai riodio riambor,
	spita nours nerei		29a. Certifier 1 Certifying P	hysicien: To the best of	of my knowledge	e, death occurred at the t	me, date and place	, and due to the	cause(s) and manner a	s stated.
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2 Medical Exe	miner: On the basis of and manner sta	examination an	nd/or investigation, in my	opinion, death occu	rred at the time,	date and place, and du	e to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (Mon	th. Day, Year)
	03		me Non	DR. USHA N	ATESON	20573	59		December	13/5 2005
	· 6, 1		30. Name and address of person who		eath (Item 23a)					
	10		1415 . S. DIVIS		JALISB de Signature	ury ME	71804			
* £ :	Sta Registr		31. Date filed (Month, Day, Year)	. 200	r's Signature		•			
	negisti	GI.	ULU 14	2005	12 S.	Marks 1				

			1 - For State Registrar	State of Mary			nt of H			F	Reg. No.	005	And the second	382	5
	Physici	an	Decedent's Name (First, Middle, Last) The last of the Total Control of the Total Contro							2. Date of Dea Month	Day	Yea	r	3. Time of De	
	/Medio	al	Ephraim F. Tal 4a. Facility Name (If not institution, give:	street and number)		4b. City	Town, or	Location of		ecembe		ounty of De		2:15 1	P."
	Examin	er	Casey House	181			kvil				Мо	ntgom	ery		
	Funeral		5. Social Security Number 6. Sec	7. Age (In	yrs. last birthday)	If Unde Months	r 1 Year Days	If Under 2	4 Hrs. 8	B. Date of Birt (Month, Day	h v, Year)	9. B	Sirthplac	e (State or F	oreign
₹	Director		577-50-8429 X Usual Residence of Decedent	8	6 Yrs.				S	Sept. 4	, 19		erma		
	yland Iow		10a. State 10b. County	100	c. City, Town or Lo	cation							10d.	Inside City I	Limits
	e Mar	ctor	Maryland Montgome	ry	Rockvi	11e								1 X Yes 2	.□ No
	be filed within 72 hours after death with the Maryland ital Hyglene. d other then "natural", or iteme 23a or 28e-f ehow dother then "natural", or iteme 20a on 28e-f ehow event. The Medical Examiner must be motified at	Funeral Directo	10e. Street and Number 6111 Montrose Road	, Apt. 222		10f. Zi	208 g	52			-	on of What o		?	
	death	nera		12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Dece	dent of Hi	spanic Origi	in? (Spec	ify Yes or No- ican, etc.)	1	4. Race - Ar			
õ	or ite		1 Never Married 2 Married	1 Yes 27 No If Yes, Give Year or Dates:		1 🔲 Yes		Specify:	r deno m	ican, etc.,		Black, WI Specify: 1	Whit		
2-003e	hours tural	ed by	3 Widowed 4 Divorced		16a. Dece		21	ition			16b. Kin	d of Busines			
ָרָ הַ	hin 72 In "ne Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of wi	ork done d ise retired,	uring most	of working	7				,	
2121	filed with Hygiene other the	Com	9 Years	Conlege (, tol. c t,	Cabi	net N	laker				Wo				
Maryland	d ta b	Be	17. Father's Name (First, Middle, Last)						,	First, Middle,	Maiden S	iu <i>mam</i> e)			
Š	should and Men a marke umatic	2	Chaim Tal 19a. Informant's Name/Relationship (Ty	ne Print)	19b Maili	na Addres	s (Street a	Dora and Number		LLich Route Numbe	r City or	Town State	Zip Co	ode)	
	nd 2 sho lith and 27 is m r traum		Judi T. de Boer -	_		•				Corrale					8
altimore,	of Heal		20a. Method of Disposition		Ob. Place of Dispo	matory or	other place	9)	Da			ation - City			
Ĕ	Peges ment of ant: If it		1 ∰Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Judean M	em. (Garde	ns 1,	/3/20	006	Olne	y, Ma	ryla	ınd	
gall	permit. Peges 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic once.		21. Signature of Funeral Service Licens	- Annual Contraction of the Cont	Ed.	e. Name a ward	nd Addres Sage	s of Facility 1 Fun	eral	Direct Rockv	ion,	Inc.			
	TI E G		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the	get 10	91 R	ockvi	11e P	ike,	Rocky respiratory ar	ille, rest	Mary	l A	pproximate	
	Physician		Immediate Cause (Final										0	terval Betweenset and Dea	
	/Medical		disease or condition resulting in death)	Due to (or as a co	nsequence of):	uri	nary	втааа	er				PIC	onth	
	Examiner	_	Sequentially list conditions,	o									-		
_	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dee to (or as a ex-	nsequence on:										
<u>,</u>	be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):										
2/60	y y	llcal		d									-		
ğ	entifica ling pt	Med	IF FEMALE:	3c. If yes, outcome of pr											
XOP	leath certific attending p	Physician/Med	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3[Ectopic p					23	d. Date of d Month	lelivery Da	ıy Yea	ar
j.	at the de by the a tached	hysl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						_					
ς, Τ	as this	þ	Part II. Other significant conditions con	ntributing to death but no	ot resulting in the u	nderlying	cause give	n in Part I.			bacco us			cause of deal	
0	w require been sign	eted							_	-					
e E	hast ge 2 s	Completed								24a. Was autop perfor	rmed?	24b. Were prior to death	o compl	r findings ava letion of caus	allable se of
Division of Vital Records,		0	25. Was case referred to medical					26 Place	of Death /	1□ Yes (Check only o	2. No	1 □ Y	es 2[□ No	
<u> </u>	Physician: r this certific ral director,	ToB	examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 Inpatient	2 ER/Outpatie	nt_3 D	OA Othe			e 5 Resid		Other (S)	pecity)	Hospi	Lce
0	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time o		28c. Injury Work		-	3d. Describe h	iow injury	occurred			
<u>s</u>	or Attending ifter death. Director: After in by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury -	At home farm et	M factor		/es 2 □N		3f. Location (S	Street and	Number or	Rural R	oute Numbe	ar.
2	al or Attend after death Director: / d in by the f	Certification:	4 Homicide determined	building, etc. (S	pecify)	66t, 1actor	y, omca			City or Tox				0410 1141100	
	To the Hospital or A within 24 hours after To the Funerel Direct completely filled in by	edical C	(Check only 2 Medical Exami	sician: To the best of my	y knowledge, deat imination and/or in	h occurred vestigation	d at the time n, in my op	e, date and pinion, death	d place, an	nd due to the o	cause(s) a	nd manner place, and d	as state	ed. e cause(s)	
	o the lithin 2 the l	Med	one) 29b. Signature and title of certifier	and manner stated.			c. License					signed (Ma			
			Chil: Or know	el				42452				ember			
	10		30. Name and address of pers in who co	ompleted cause of death	(Item 23a) (Type,	Print)		,		1					
			Dr. Chitra Raj		Muncast	er Mi	11 R	oad, R	Rockv	ille,	Mary	Land	208	55	1
100	Sta Registi		31. Date filed (Month, Day, Year) JAN 0 6	32. Régistrar's 9	Signature	books									

December State Part Media: Last Section				1 - State of Maryland / Department of Health and M Certificate of Death		-211115	43826
SANDRA MARTE WILHIDE STANDING SOCIAL SECTION OF THE STANDING STA		Diini		Decedent's Name (First, Middle, Last)			3. Time of Death
Source Prince Courty 3 10 10 10 10 10 10 10	1			SANDRA MARIE WILLHIDE			7:55 p M
Social Society Social Social Social Social Social Social Society Social Social Society Society Social Society Social Society Social Society Social Society Social Society Social Society Social Society Social Society Society Social Society Social Society Social Society Social Society Society Society Society Society Social Society Society Society Society Society Society Society Society Society Society Societ		Examir	ner			Reg. No. Date of Death Month Day Year Pecember 28, 2005 7:55 4c. County of Death Prince George's Act Country of Death Prince George's Date of Birth (Month, Day, Year) (av 10, 1939 Washington, 10d. Inside Cit 1X Yes 10g. Citizen of What Country? U.S.A. Yes or No- an, etc.) 16b. Kind of Business/Industry Prince George's County Police Depairst, Middle, Maiden Sumame) Kernan Oute Number, City or Town, State, Zip Code) Bowie, Maryland 20716 20c. Location - City or Town, State /2005 Washington, DC h's Funeral Home, P.A. e, Hyattsville, MD 20783 Approximate Interval Belw Onset and D 23d. Date of delivery Month Day Year 23d. Date of delivery Month Day Year 23d. Date of delivery Month Day Year 24a. Was an autopy findings a prior autopy findings a prior autopy findings and prior aut	
The property of the property				3006 Arden Forest Lane Bowie	Data of Rid	Prince (George's
United Recording of Control (1997) The Control of Cont				1 M 2 M F Months Days Hours Min.	(Month, Day		
Star Star Star Star Star Star Star Star				Usual Residence of Decedent	May IU	1939 Was	nington, DC
Star Star Star Star Star Star Star Star		urylan show	_	10a. State 10b. County 10c. City, Town or Location			
Star Star Star Star Star Star Star Star		Ba-f s	octo				**
Star Star Star Star Star Star Star Star		with th		1.1.2		10g. Citizen of What C	ountry?
Star Star Star Star Star Star Star Star		eath	eral		acifu Vac or No-		orican Indian
Star Star Star Star Star Star Star Star		fterd	F	Armed Forces? 1 Never Married 2 Married 1 Yes 2 T No	Rican, etc.)	Black, Whi	
Star Star Star Star Star Star Star Star	93	al', o	by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:		Specify:	Vhite
Star Star Star Star Star Star Star Star	5-0	72 ho	eted		ina		
Star Star Star Star Star Star Star Star	21	ithin ne. han	du	Elementary/Secondary (0-12) College (1-4or 5+)			0
Sillas Allen Potter Sillas Allen Potter 19th Mailing Address (Streat and Number or Runal Patron Number, City or Town, State, Zip Code) Judoth A. Davis - Daughter 19th Mailing Address (Streat and Number or Runal Patron Number, City or Town, State, Zip Code) Judoth A. Davis - Daughter 19th Mailing Address (Streat and Number or Runal Patron Number, City or Town, State, Zip Code) Judoth A. Davis - Daughter 19th Mailing Address (Streat and Number or Runal Patron Number, City or Town, State, Zip Code) Judoth A. Davis - Daughter 19th Mailing Address (Streat and Number or Runal Patron Number, City or Town, State, Zip Code) Judoth A. Davis - Daughter 19th Mailing Address (Streat and Number or Runal Patron Number, City or Town, State, Zip Code) Judoth A. Davis - Daughter 19th Mailing Address (Streat and Number or Runal Patron Number, City or Town, State, Zip Code) Judoth A. Davis - Daughter 19th Mailing Address (Streat and Number or Runal Patron Number, City or Town, State, Zip Code) Judoth A. Davis - Daughter 19th Mailing Address (Streat and Number or Runal Patron Number, City or Town, State, Zip Code) Judoth A. Davis - Davis		iled v Hygie Iher t			/Eiret Middle		ice Department
Judeth A. Davis - Daughter 3006 Arden Forest Lane, Bowie, Maryland 20716 20a Memodo Disposition 1	and	d be f antal }		011 111 7			
Judeth A. Davis - Daughter 3006 Arden Forest Lane, Bowie, Maryland 20716 20a Memodo Disposition 1	<u>-</u>	should Me Me mark	ř				Zip Code)
Recommendation of Commendation		교육등학					
Continued Cont	ē,	s 1 a of Hea Item		20a. Method of Disposition 20b. Place of Disposition (Name of	Date		
23. Fart. Enter the disease, or completitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate dates (Final Tender the disease, or completitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate dates (Final Tender the mode of dying, such as cardiac or respiratory arrest, immediate dates (Final Tender the mode of dying, such as cardiac or respiratory arrest, immediate dates (Final Tender the mode of dying, such as cardiac or respiratory arrest, interval Bouveau	E	Page nent c int: If iry or		1 X Buriai 2 Cremation 3 Chemoval from State	1/2005	Washington	n. DC
23. Fart. Enter the disease, or completitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate dates (Final Tender the disease, or completitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate dates (Final Tender the mode of dying, such as cardiac or respiratory arrest, immediate dates (Final Tender the mode of dying, such as cardiac or respiratory arrest, immediate dates (Final Tender the mode of dying, such as cardiac or respiratory arrest, interval Bouveau	att	ppartm ports y inju				neral Home	, P.A.
Physician (Nedical Examiner Part Class Charles Class Charles Class Charles Class Charles Class Charles Class Charles Class Charles Class Charles Class Charles Class Charles Class Charles Class Charles Class Class Charles Class	_	90 E 29	9 17				MD 20781
Company Comp				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac c shock, or heart failure. List only one cause on each line.	or respiratory are	rest,	Interval Between
Sequentially list conditions, flavy, leading to immediate gause. Enter Underlying that indiated events resulting in death) Last Sequentially list conditions, flavy, leading to immediate gause. Enter Underlying that indiated events resulting in death) Last Sequentially list conditions, flavy, leading to immediate gause. Enter Underlying that indiated events resulting in death) Last Sequentially list conditions, flavy, leading to immediate gause. Enter Underlying that indiated events resulting in death) Last Sequentially list conditions, flavy, leading to immediate gause. Enter Underlying that indiated events resulting in death) Last Sequentially list conditions, flavy, leading to immediate gause. Enter Underlying that indiated events resulting in death) Last Sequentially list conditions, flavy, leading to immediate gause. Enter Underlying that the gause gause resulting in death) Last Sequentially list conditions, flavy, leading to immediate gause. Enter Underlying that the gause gause gause gause in Part I. Sequentially list conditions, flavy, leading to immediate gause. Enter Underlying that gause gause gause gause in Part I. Sequentially list conditions, flavy, leading to immediate gause. Enter Underlying that gause gause gause gause in Part I. Sequentially list conditions, flavy, leading to immediate gause gause gause in Part I. Sequentially list conditions, and sequentially list conditions, and sequentially list conditions, and sequentially list conditions, and sequentially list conditions, and sequentially list conditions, and sequentially list conditions, and sequentially list conditions, and sequentially list conditions, and sequentially list conditions, and sequentially list conditions, and sequentially list conditions, and sequentially list conditions, and sequentially list conditions, and sequentially list conditions and sequentially list conditions and sequentially list conditions and sequentially list conditions and sequentially list conditions and sequential list list conditio				disease or condition Lymphoma			Onset and Death
The standard of the standard o				Due to (or as a consequence of):			
The first state of the state of			ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
FFEMALE: 23b. Was decedent pregnant 1 Live bird 2 Fetal death 3 Ectopic pregnancy 1 Live bird 2 Fetal death 3 Ectopic pregnancy 1 Live bird 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy 1 Live bird 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 1 Year 2 No. 9 Unknown		uted d ansit	듄	cause. Enter Underlying Cause Observed winty			
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1	o,	an an rial-tr	Exa		-		
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1	376	ate be nysicii he bu	Ca	d			
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1	9	artifica ing ph e as t	Med	JF FEMALE:			
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1	B0)	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?			,
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1		the a	yslc	1 Tyes 2 No 9 Unknown 9 Unknown			
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1	<u>α</u>	that t ed by detai		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1	ds	puires n sign lid be		Chronic Obstructive Pulmonary Disease	1 🗆 Y	es 2 No 3 P	robably 4 🖔 Unknown
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1	00	s beel	lete		24a. Was a	an 24b. Were a	utopsy findings available
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1	Re	The la te ha	mo		perfor	med? death?	
The state of the s	ita		0				2010
1 Natural 2 Accident 3 Suicide 4 Homicide 4 Homicide 5 Pending investigation 5 Pending investigation 5 Pending investigation 6 Could not be determined 288. Place of Injury · At home, farm, street, factory, office 281. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and didress of person who completed cause of death (Item 23a) (Type, Print) Natheral Route Number or Rural Route Number, city or Town, State) 29b. Signature and title of certifier 29b. Date signed (Month, Day, Year) 29b. Signature and death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29b. Date signed (Month, Day, Year) 31. Date filled (Month, Day, Year) 31. Date filled (Month, Day, Year) 32. Registrat's Signature and Sig	f <	hysic Ins ce	0	examiner?			
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen Anne Kemmer, MD 900 Bestgate Road, #300, Annapolis, Maryland 21401	n o				28d. Describe h	ow injury occurred	Residence
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen Anne Kemmer, MD 900 Bestgate Road, #300, Annapolis, Maryland 21401	Sio	tend death tor: /	catl	2 Could not be	ORA Lanation (C		
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen Anne Kemmer, MD 900 Bestgate Road, #300, Annapolis, Maryland 21401	١	after of Direction by	ertif	determined 200. Flace of Injury : Actions, latti, street, lactory, office			urai Houte Number,
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen Anne Kemmer, MD 900 Bestgate Road, #300, Annapolis, Maryland 21401		spita ours neral filled		29a. Certifier 1 \(\mathbb{Z}\) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the c	ause(s) and manner a	s stated.
5 D59173 i-3-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen Anne Kemmer, MD 900 Bestgate Road, #300, Annapolis, Maryland 21401		n 24 h	adic	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	ed at the time, d	ate and place, and due	to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen Anne Kemmer, MD 900 Bestgate Road, #300, Annapolis, Maryland 21401		To the To the comp	Σ		2	9d. Date signed (Moni	th, Day, Year)
Kathleen Anne Kemmer, MD 900 Bestgate Road, #300, Annapolis, Maryland 21401)			D59173		1-3-06	
31. Date filed (Month, Day, Year)		(5)					
Registrar JAN 0 5 2006 Steven & Specific				31. Date filed (Month. Day Year)	apolis,	Maryland 2	21401
				JAN 0 5 2006 Keen & Spell			

	ı	ho	1 - For State Registrar	State of M	arylan	•	artmen	t of H	ealth a	and M	lental Hyg		n n	<u></u>	13827
90	Dhusia		1. Decedent's Name (First, Middle, La	st)							2. Date of Deat		1	Voor	3. Time of Death
P			Dorothy Wo	lfe							December	31,	, 20	05	12:03 P₩
December Certificate of Death Company December				4c. C	ounty of	f Death									
Į,		SÉ											ontg	year 3. Time of 12:03 ty of Death tgomery 9. Birthplace (State or New York) 10d. Inside City 1 Yes f What Country? S. A. ace - American Indian, ack, White, etc. iffy: U. S. A. Business/Industry vate Ime) Maryland 208 Inc. City or Town, State Maryland Inc. Marylan	У.
			156-09-1957								8. Date of Birth (Month, Day, Oct. 1,	Yea <i>r)</i> 191	18	9. Birthpt Count New	tace (State or Foreign Tork
	land ow				10c. City	, Town or Lo	cation							10	Od. Inside City Limits
	Many i-f eh fied	ţō	Maryland Montgom	erv	Si1	ver Si	nring								1 Yes 2 No
	or 28s	irec						Code			16	g. Citize	n of Wh	nat Count	try?
	23a c	aiD	15100 Interlachen	Drive, #	225			209	06			U.	. s.	Α.	
	r dea	nei	11, Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.	Was Deced	dent of Hi	spanic Ori n, Mexicar	igin? (Spe	ecify Yes or No- Rican, etc.)	14			
36	or II	y F.		If Yes, Give	No							S	pecify:		
9	ture!		Λ			16a Dece	dent's Heur	al Occups	ation			Ch Kind	of Buci		
15	n "na	piet	(Specify only highest gra	ade completed)		(Give	kind of wo	rk done d se retired	luring mos	t of worki	ng	bb. Kind	or Busi	iness/ind	lustry
212	d with	Eo	Elementary/Secondary (0-12)	• '		Marl	ket R	esea	rcher	•		Pr	civa	te	
פָּ	al Hyg othe		17. Father's Name (First, Middle, Last)	-				18. Mothe	er's Name	(First, Middle, N	laiden Si	umame))	
/lai	uld b Venta rrked rife e	0	Samuel Stern						Re	becc	a Pagoda	ι			
Man	nd 2 sho alth and 1 27 is ma g trauma				r										
ľe,	F Hee		·	_	20b. Pt	ace of Dispo	sition (Nar	ne of	al	D	ate 2	Oc. Loca	ition - C	ity or Tov	wn, State
Ĕ	Page nent c				1	-			·	/04/	2006	lney	y, M	ary1	and
alti	partn ports y inju		21. Signature of Funeral Service Licer	1see		22 F	Name an	d Addres	s of Facilit	y	1 Direct	ion	Tn		
<u>m</u>	8978		Donald (.	Ltotte	imy	1	091 R	ockv	ille	Pike	, Rockvi	11e	, Ma	ry1a	and 20852
	/Medical Examiner	icai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	consequ	ence of):	kal)	Thy	lor	eféor				
.O. Box 6	the death certifica by the ettending ph ached for use as th	nysician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at	2 Fetal	death 3						230	d. Date (-
۵.	res that igned b	by	Part II, Other significant conditions of	ontributing to death b	ut not resu	lting in the ur	nderlying c	ause give	n in Part I.						
ord	requi	eted									1 Yes	2 🗆 1	No 3	☐ Proba	bly 4 Münknown
I Rec	The law sate has b page 2 s	Comple	9-9-10-10-10-10-10-10-10-10-10-10-10-10-10-								24a. Was an autopsy perform	ed?	prio	or to com ath?	pletion of cause of
Vita	ician Sertifi ector	00		Magnital.				Tou.		of Death	(Check only one)			
of	Phys this al dir			1 M Inpatie				A	4 🗀 140						
no	ding h. After funer	tion	Natural 5 Pending	(Month, Da	y Year)			Work	?		8d. Describe nov	v injury o	ccurred		
Division	of or Attendated after death Director:	ertifical	3 Suicide 6 Could not b	e 28e. Place of Inju	ury - At hor c. (Specify)	me, farm, stre			95 2 1		8f. Location (Stre City or Town,	et and N State)	Vumber	or Rural	Route Number,
	• Hospite 24 hours • Funeral etely filler		Check only 2 Medical Exar	niner: On the basis of	f examinati	vledge, death on and/or inv	occurred vestigation,	at the time in my op	e, date and inion, deat	d place, a th occurre	and due to the car ad at the time, da	use(s) an e and pla	id mann ace, and	er as sta d due to	ited. the cause(s)
	To the within Fo the complex	Me	29b. Signature and Wiley of centrier				290				29	d. Date s	igned (i	Month, D	lay, Year)
	11) THOO.					28	Sod	3.		7/	01	21	200
	10		30. Name and address of person with	completed cause of d	eath (Item	23a) (Type. I	Print)			-		11.	U	. ~	706
			Dr. Qázi Anjum			Avenu	e,#	440,	Tako	oma P	ark, Mai	ylar	nd	2091	2
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 6 2	32/Registra	ar's Signal	LITE AND	will								

			State of Maryland / Department of Health and Me Certificate of Death	, 0	2005 12020
				Reg. 2. Date of Deeth	3. Time of Death
	Physic /Medi			Month /2	Day Year 2143°
>	Exami		4a_Fecility Name (If not institution, give street and number) 4b. City, Town, or Loca	ation of Death	4c. County of Death
			PRINCE GEORGES HOSPITAL CENTER CHEVERL	/	rince Gorge's
п	Funeral Director		5. Sociel Security Number 6. Sex 7. Age (in yrs. last birthday) Origin Teal If Orig	3. Date of Birth (Month, Day, Ye 10-27-05	
	·		Usuel Residence of Decedent	10-27-03	MARYLAND
	show date	_	10e. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	the M 28a-f	Director	MD PRINCE GEORGE'S SEAT PLEASANT 106. Street end Number		1 ☐ Yes 2 ☐ No
	3a or				Citizen of What Country?
	death	Funeral	11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Ri		14. Race - American Indian,
020	within 72 hours after death with the Maryland ene. than "naturel; or items 23s or 28s-f show he Medical Examiner inust be notified at	by Fu	Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, specify Cuban, Mexican, Puerto Ri 1 Yes, specify Cuban, Puerto Ri 1 Yes, speci	can, etc.)	Black, Whita, etc. Specify: BLACK
5-0	72 hc netui	eted	15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b	Kind of Business/Industry
Maryland 21215-0020	filed within Hygiene. other than	Completed by	Elementary/Secondary (0-12) College (1-4or 5+) NONE		ONE
/land	9 a b ≥	To Be	17. Fetner's Name (First, Middle, Last) 18. Mother's Name (i		en Surname)
	1 and 2 should Health and Men em 27 is market wher traumatic		19a. Informant's Name/Relationship (Type, Print) ROBIN E. ANDERSON/MOTHER 19b. Mailing Address (Street and Number or Rural No. 1) 510 62nd PLACE # B SEAT		
Baltimore,	ant of at: if it		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) RIVERDALE CREMATORY 1/		Location - City or Town, State VERDALE, MARYLAND
Balti	permit. Pa Departmar important: any injury ance.		21. Signature of Funeral Service Licensee 22. Name and Address of Fecility J.	B. JENKIN	IS FUNERAL HOME
			7474 LANDOVER ROAD La		Approximate
1	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or r shock, or heart failure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in death) e	espiratory arrest,	interval Between Onset and Death
	D	iner	Due to (or as a consequence of):		
Ö,	ificate be execute g physician and as the burial-tran	Examiner			
68760,	rtificate be executed ng physician and sas the burial-transit	Medical	resulting in death) Last Due to (or es e consequence of):		
Вох	ath ce ttendii or use	Physician/M	d		
<u>о</u> .	the a	ysic	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobaco	co use contribute to the cause of death?
	gned by be datac	2		1 🗆 Yes	2 ☑ No 3 ☐ Probably 4 ☐ Unknown
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death cat 10 the Lunesi Directors. After this certificate has been signed by the attending completaly filled in by the funeral director, page 2 should be datached for use.	Completed		24a. Wes en eu performed?	24b. Were autopsy findings available prior to completion of cause of deeth?
<u>~</u>	The laste his page	Co		1 ☐ Yes	2 ☐ Yes 2 ☐ No
<u> </u>	Physician: r this certific wal director,	m	25. Was case referred to medical examiner? 1 Yes 2970 Hospital: Theretical 26. Place of Death (C	Check only one)	
ō	rthis eral di	15	1 ☐ Yes 2 ☐ No	5 Residence	6 □Other (Specify)
<u>ö</u>	Attending or death. ector: Aftar by the fune	ation	1 ☑Natural 5 ☐ Pending (Month, Dey Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No		
DIVIS	ii or Atte after de Directo d in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	Location (Street City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completaly filled in by tha funer	edical C	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place, and manner steted.	due to the cause at the time, date a	s) end manner es steted. nd place, and due to the cause(s)
	To the within 2 To the comple		29b. Signature and title of certifier 29c. License number	29d. D	ate signed (Month, Day, Year)
			Jama J. Jing, MD D47+37	10	2/30/05
2	(1)		30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) LAURA L. JENNINGS, 2001 HOSPITAL DRIVE, CHEVERL	Y, MD &	20785
	Sta Registra	ie i	- 1841 4 0 mode W. h. de W. de		

DHMH 16 Rev 6/95

			1 - For State Registrar	ate of Maryl	and / Dep		of H	ealth a		ental Hyg		05	43829
	Physici	an	Decedent's Name (First, Middle, Last)	7 Pogost						2. Date of Deat Month Decembe		200ger	3. Time of Death
}	/Medic Examir	cal	Reynard Lynwood 4a. Facility Name (If not institution, give street Genesis Long Green				Town, or	Location of		Decembe	7	nty of Death	1:30 a. M
	Funeral Director		5. Social Security Number 219–06–8220 6. Sex		vrs. last birthday Yrs.	y) If Under Months	1 Year Days	If Under 2 Hours		8. Date of Birth 09/01/1	969 9	9. Birth	place (State or Foreign intry)
	how		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or I								10d. Inside City Limits
	r 28e-f	recto	MD 10e. Street and Number		Balti	10f. Zip	Code			10	Og. Citizen o	of What Cou	1 Yes 2 □ No intry?
	23a ol	ra! Di	501 E. Preston Street	et			212				1	USA	
920	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel; or Itame 23a or 28a-f ehow any injury or other traumatic event, Ita Medical Erariti at rusal be rustified at ADE.	by Funeral Director	1X Never Married 2 Married 1 If	/as Decedent Ever in med Forces? ☐ Yes 2X No Yes, Give ear or Dates:	n U.S. 13	I. Was Decede If Yes, speci		spanic Orig n, Mexican, Specify:	in? (Spec Puerto R	orty Yes or No- lican, etc.)	В	Race - Ameri Black, White, cify: Bl a	, etc.
150	in 72 hc n "natur Nedical	Completed	15. Decedent's Education (Specify only highest grade com	npleted)	16a. Dec (Giv life.	edent's Usual ve kind of work DO NOT use	l Occupa k done di e retired)	tion uring most	of working	g	16b. Kind of	Business/Ir	ndustry
212	ed with ygiene.	Com	8th	ollege (1-4or 5+)		chanic					Diese		
Maryland 21215-0036	world be fill Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last) Robert Lee Becog	at						(First, Middle, M a Carr	faiden Sum	ame)	
	alth and 27 is mu		19a. Informant's Name/Relationship (Type, P Timothy Carr (b r		19b. Mai 131	8 Dart	(Street a	nd Number h Ave	or Rural	Route Number, arkvill	City or Tow e, MD	vn, State, Zij 21234	o Code) 1
Baltimore,	Pages 1 and of He Int: If Item		20a. Method of Disposition 1		b. Place of Disp cemetery, cri Sacred	ematory or other	her place	12	Da 2/29/			n - City or T	
Balti	permit. Depertri Importa any Inju		21. Signature of Funeral Service Licensee Wesley Chavis Jr.	. per D		22. Name and Wesle	Address y Ch	of Facility avis	Jr.	F.H., 2	007 E	asterr	n Ave. D 21231
,092	Physician // Medical // Medical // Lysician and // Lysician an	ilcai Examiner	23a. Part1. Enter the disease, or complication shock, or heert failure. List only one cal Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last d	use on each line. End Stage Due to (or as a constitution of the	Human sequence of):	Immuno	defi	cienc	y Sy	ndrome			Approximate Interval Between Onset and Death
.O. Box 68	The law requires that the death certitica site has been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	in the past 12 months?	yes, outcome of pre □Live birth 2 □ F □Pregnant at time o □Unknown	etal death 3	□Ectopic pre						Date of delive	ery Day Year
<u>α</u>	quires that to signed by aid be deta		Part II. Other significant conditions contribut Seizure Disorder	ing to death but not	resulting in the	underlying ca	use giver	n in Part I.					he cause of death?
Division of Vital Records,	The lay ste has page 2	Completed								24a. Was an autopsy perform	ed?	D. Were auto prior to co death? 1 \(\sum \text{Yes}	opsy findings available impletion of cause of
Zita Zita	sician: Th s certificate lirector, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	al: 1 ☐ Inpatient 2	□ EB/Outpatie	ant 3 17 100/				Check only one e 5 🗆 Resider		other /Coord	£.)
on of	Attending Physician: r death. sctor: After this certifici	ion: To	27. Manner of Death 1 X Natural 5 ☐ Pending	a. Date of Injury (Month, Day Year	28b. Time		c, Injury Work	at es 2 N	28	3d. Describe hor			y /
Division	s after death s after death b) Director: , ed in by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 280	e. Place of Injury - A building, etc. (Spe	t home, farm, s ecify)			63 2 110		If. Location (Str. City or Town,		mber or Rura	al Route Number,
	To the Hospital or At within 24 hours after of To the Funerel Direc completely fitted in by	edical (29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner: Cartifying Physician 2 Medical Examiner: Cartifying Physician 2 Certifying Physician	: To the best of my on the basis of examind manner stated.	knowledge, dea ination and/or i	ath occurred a investigation, i	t the time in my opi	e, date and nion, death	place, an	nd due to the ca d at the time, da	use(s) and r te and place	manner as s e, and due to	stated. the cause(s)
	To the complex	Me	29b. Signature and title of pertifier	QB.	Olu		License 2168			29	d. Date sign	neit (Month,	Day, Year)
	(J)		30. Name and address of person who complete Howard B. Cohen, M.	ed cause of death (ID., 6717	tem 23a) (Type Park He	eights	Aven	we, E	Balti	more, M	D 212	15	V
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 5 2006	32. Registrar's Si	nature	w							

Amended #5, nls, 1/9/06, Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 43830 Certificate of Death Reg. Ñő. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Robert Arthur Bates December 27, 2005 6:25 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Devlin Manor Health Care Center Cumberland Allegany If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 371-22-7653 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Months 1 X M 2 □ F Yrs Director -02 - 770580 10/02/1925 Michigan Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mentel Hygiene. Important: If Item 27 is marked other than "neturel; or Items 23s or 28e-f show eny Injury or other traumstic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cumberland 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10301 Christie Road, NE 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify. ģ 3 ☐ Widowed 4 N Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Contractor Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Arthur Bates Ethe1 Bramwe11 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Luann J. Gaglio / daughter Route 1 Box 102A, Ridgeley, West Virginia 26753 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 12/28/2005 Cumberland, Maryland 21. Signature of Auneral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, Maryland 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of Physician/Medical Examiner attending physician end for use es the bunel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) resulting in death) Last ed by the a deteched f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed by ģ page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peen has 20 No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending death. investigation 1 Tyes 2 □ No Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital 24 hours till Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D33280 December 27, 2005 بى 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunil K. Gupta, M.D., 625 Kent Avenue, Cumberland, Maryland 31. Date filed (Month, Day, Year) 32. Regiarar's Signature State DEC 2 7 2005 Registrar 1. Grade

			1 - For State Registrar 1. Decedent's Name (First, Middle,		Maryland / De	ertificate of			Reg. No.	J	3 Time of 2
	Physici /Medi		Barto	n Emilio C				Month Decembe	Day	Year 2005	3. Time of Death 4:13 P
}	Examir	ner	4a. Facility Name (If not institution,			4b. City, Town, o	r Location of Death		4c. Count	y of Death	
			Prince Geor				hever1y		Pri	ince (George's
	Funeral Director		579-68-8964	3. Sex 1 M 2 □ F	Age (In yrs. last birthda 54 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th	9. Birthp	place (State or Foreigntry) h DC
	pu k		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	l anation		- 1007			
	Maryla 9-f sho	tor	DC		Too. Oity, Town of	Location	Washir	gton			10d. Inside City Limits 11 Yes 2 □ No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?
	th wil	a	427 - 61st	St., N.E.			20019		TI ₁₂	ited	States
	deal	ner	11. Marital Status	12. Was Deceder	t Ever in U.S. 13	. Was Decedent of H If Yes, specify Cuba		ecify Yes or No	- 14. Ra	ce - Americ	can Indian,
030	thin 72 hours after death with the Maryland e. en "natural", or items 23a or 28e-f show Madical Examina must be notified at	þ	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces d 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	No	If Yes, specify Cuba 1 ☐ Yes 2 No	an, Mexican, Puerto Specify:	Rican, etc.)	Speci	ry:	ican
Ş	2 ho	ted	15. Decedent's	Education	16a. Dec	edent's Usual Occup	ation		16b, Kind of E		erican
9500-61212	d within 7 piene. r then "n	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-40	life	e kind of work done of DO NOT use retired Program	du <i>ring</i> most of work d) m Assista	-		vernm	,
	filed Hygi offher	Be Co	17. Father's Name (First, Middle, Li	ist)		110614	18. Mother's Nam				
Maryland	Q to 0	To B	Theodore W.	Adams, Sr	•			Ruth	C1emons		
Jar	and and ls my	0 1	19a. Informant's Name/Relationshi			ling Address (Street					Code)
	1 and Health em 27 other tr		Lydia G. Cler	nons - Wife		27 - 61st			, DC 20	019	
баітітоге,			20a. Method of Disposition 1 Burial 2 Cremation 3	☐Removal from Stat	9	ematory or other place	:e)	Date	20c. Location	- City or To	own, State
	it. Partiment		'4 ☐Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Li			Memorial I		-		over,	
D	permit. Pages Department of Important: If i any injury or once.		21. Signature of Purietal Service El	ST0 ()	W.	22. Name and Addres			Funeral		
			23a. Part1. Inter the disease, or c shock of heart failure. List of	omplications that cause	ed the death. Do not e		nning Rd.			DC 20	O19 Approximate
3	Priysician		shock on heart failure. List of Immediate Lause (Final disease or Ition resulting in death)	a. TATAL	CARDIÁC	ARRHYT					Interval Between Onset and Death
	/Medical Examiner			PROPAR	s a consequence of):	5					
	MAKE.	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	s a consequence of):	,	10.0	,			
	icuted nd Iransii	Examiner	that initiated events	· ACUT		RDIAL /1	NFARCTIO	N			
Ď,	ificate be executed g physician and as the burial-transit	a Ex	resulting in death) Last	Due to (or a	s a consequence of):						
6876U,	tificate ig phys as the	edlcal		d							
	death certi	M/UR	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		□			23d. Da	te of delive	ry
	ires that the death cer signed by the attendin d be detached for use	Physiclan/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			□Ectopic pregnancy □ Other (specify)			Mo	onth	Day Year
L	s that ned b	by Pf	Part II. Other significant condition	s contributing to death	but not resulting in the	underlying cause give	en in Part I.	23e. Did to	obacco use cont	ribute to th	e cause of death?
vital necords,	The law requires that the ate has been' signed by th page 2 should be detache							1 🗆 Y	res 2□No	3 🗌 Prob	ably 4 🏋 Unknown
2	lawr nas be	Completed						24a. Was		Were autor	osy findings available
=	: The law cate has l . page 2 s	Con						perfor	rmed?	death? 1 🗌 Yes	-
716	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Unanitati			26. Place of Death	Check only o	ne)		
5	S 0 70	은	1 ☐ Yes 2 ▼No	Hospital: 1 Inpat			4 - Industrig Ho)
	ding h. After fune	atlon	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Inj (Month, D		Work	rat (? Yes 2 □ No	28d. Describe h	low injury occur	red	
DIVISION	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 286. Place of It	ijury - At home, farm, s tc. <i>(Specify)</i>	treet, factory, office		28f. Location (S City or Tow	Street and Numb in, State)	er or Rurai	Route Number,
	0 0 W	edical C	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the bes aminer: On the basis and manner s	t of my knowledge, dea of examination and/or i	th occurred at the tim	ne, date and place, pinion, death occurr	and due to the ded at the time, d	cause(s) and ma date and place,	inner as sta and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1		29c. License	number		29d. Date signe	d (Month, L	Day, Year)
			1	A 111	_	7 8	58951		1/3	106	
	(11)		30. Name and address of person wh	o completed cause of	death (Item 23a) (Type	, Print)	CHEVER		10.00 -	-	
			DR CARRY LYTTLE	3001	HOSPITAL	DRIVE	CHEVER	U, MD	XV 785		
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 9 20		rar's Signature	Al a					

			For State Registrar		State of Ma	aryland /	-	ment of icate of				giene Reg. No.	005	43832	
	Physicia /Medic	al	KATH	e (First, Middle, Las ER/N	E	_	RMI			D	ECE HI	BERZY	31,200	3. Time of Death 3,30-PM	
	Examin Funeral Director		4a. Facility Name (I HEBRE 5. Social Security N 012-05-3	EW Hon		WAShi ater (In yrs. last 94	birthday) If	Under 1 Year onths Days	S OCK	r 24 Hrs. 8	B. Date of Birt (Month, Da	h v, Year)	Co	th MERY hplace (State or Foreign buntry) Ssachusetts	
	D		Usual Residence of	Decedent 10b. County		10c. City, To	own or Locati	on						10d. Inside City Limits	
	Maryi	tor	MD	Montgome	ry	Rock	ville							1 Yes 2 No	
	vith the	Director	10e. Street and Nur	trose Roa	4			10f. Zip Code	200	852		10g. Citiz	en of Whal Co	ountry?	
	J within 72 hours after death with the Maryland jiene. I than "natural", or Items 23e or 28e-f show I've Medical Examinat must be notified at	Funeral	11. Marital Status	ied 2□ Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 [X]N				Hispanic Or ban, Mexica	rigin? (Spec an, Puerto R	ify Yes or No- ican, etc.)		USA 4. Race - Ame Black, Whit		
3-003p	72 hours after netural', or Ite	d by	3 XWidowed		If Yes, Give Year or Dates:			Yes 251No		/: 			Specify: Wh:		
-6171	within 72 lene. then "net	Completed	(Special Special 15. Decedent's Ed cify onfy highest gra- ondary (0-12)			(Give kind life. DO	's Usual Occu d of work done NOT use retir maker	ipation e during mos ed)	st of working	9		nd of Business	industry		
landz	be filed Ital Hygi of other event, I	Be Co	17. Father's Name	(First, Middle, Last)			1101110	indico I	18. Moth	ner's Name	(First, Middle,			****	_
<u>S</u>		Tof		able Patk		1	Oh Mailing (ddrass (Strae		obtain		or City or	Town, State, 2	Zin Code)	_
M	d 2 h a 7 15 15 16			rmier, So	**		3				esda,	. ,		zip Code)	
nore,	of Hi				Removal from State	1		on (Name of ory or other pla Cremato		Jan 6	te 2006		ation - City or	Town, Slate	
Baltimor	permit. Pag Department Important: any injury o			neral Service Licen	- a -	0	22. N	ame and Addr	ess of Facil	lity Affo	rdab1e	Fun	eral Se A 22042	rvice	
	Physician	ñ .	shock, or hea Immediate Cause	irt failure. List only (Final	olications that caused one cause on each lin	the death. D	o not enter t	ne mode of dy	ring, such as	panta .	respiratory ar	,		Approximate Interval Between Onset and Death	
Ī	/Medical Examiner		disease or condition resulting in death)		a. Due to (or as	a consequen	parof): De	= MC	EN	TIM	7				
, 60,	icate be executed physician and sthe burial-transit	al Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	onditions, nmediate orlying injury s Last	Due to (or as c. Due to (or as						•				
O. Box 68/60	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2[9 □ Unknown	months?	23c. If yes, outcome 1 Live birth 4 Pregnant al	2 Fetal dea	ath 3⊡Ec	topic pregnan her (specify)	су			2	3d. Date of del Month	ivery Day Year	
٦.	w requires that to be a signed by should be detailed.	by	Part II. Other signi		ontributing to death b	ut not resultin	g in the unde	rlying cause g	iven in Part	. I.		obacco us		the cause of death?	
I Kecords,		Completed									24a. Was autop perfo 1 Yes		prior to death?	topsy findings available completion of cause of	7
Vital	ician: Th certificate rector, pag	Be	25. Was case reference examiner?		Hospital:			0	than 16 2	/	(Check only a				
ō	ing Phys After this uneral di	tion: To	1 Yes 2 2 27. Manner of Dear 1 Natural 2 Accident		28a. Date of Inju (Month, Da	ry 28	Outpatient b. Time of Injury	28c. Inj	41,974	28	e 5 ☐ Resid		Other (Spendocurred	cify)	-
Division	iel or Attendi s after death. al Director: A ed in by the fu	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injubulding, etc		, farm, street	factory, office	9	28	Bf. Location (5 City or Tox	Street and vn. State)	Number or Ru	ural Route Number,	
	Hospi 24 hour Funer tely fill	Medical	29a. Certifier (Check only one)	1 XCertifying Ph 2 Medical Exam	ysician: To the best niner: On the basis of and manner sta	examination	dge, death or and/or inves	curred at the tigation, in my	time, date a opinion, de	and place, areath occurred	nd due to the	cause(s) a date and	and manner as place, and due	stated. to the cause(s)	
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	Mec		title of centiler	11/1	-	HD	29c. Licer	354	36	1	29d. Date	signed (Mont	h, Day, Year) 31, 2005	
ņ	(3)		30 Name and add	ress of person who	completed cause of d	eath (Item 23	a) (Type: Pri	NIEL	350	DAO	DICV.	V111	E H	D 20852	2
	Sta Regist		OT. Date mod prior	nth, Day, Year) N 0 9 2006	_ riogioti	ar's Signature					, , , , , , ,			0 02	-

			1 - For State Registrar	State of Maryl			f Health a of Death	ind Ment		erje ()	05	438	33
П	Physici	an	Decedent's Name (First, Middle, Last)						ate of Death onth	Day	Year	3. Time of	Death
	- /Medic	al	Ann Ostandorf	Church					ember		2005	7:55	A M
	Examin	er	4a. Facility Name (If not institution, give s		-		m, or Location of	f Death			inty of Death		
	Funeral	-	Washington Advent 5. Social Security Number 6. Sex		⊥ yrs. last birthday)	Takor If Under 1 Ye	na Park ear IfUnder2	24 Hrs. 8. Da	ate of Birth	MON	TGOME!	RY place (State of	r Foreign
	Director		579-46-1517	M 2DE	83 Yrs.	Months Da	ys Hours	Min. (N	onth, Day, Y /08/19	^{ear)}	Cou	1and	roreign
	pur *		Usual Residence of Decedent 10a, State 10b, County	100	. City, Town or Lo	antin m							
	Maryik f sho	ō	,									10d. Inside Cit 1 ☐ Yes	
	the h	rect	Maryland Montgom 10e. Street and Number	ery S	ilver Sp	10f. Zip Cod	de		100	. Citizen	of What Cou		
	th with	al D	1131 University B1	vd. West #6	1	20	902			US		,	
	ams a	iner		2. Was Decedent Ever in Armed Forces?			of Hispanic Orig Cuban, Mexican,	in? (Specify Y	es or No-	14. F	Race - Americ Black, White,		
36	s afte	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 1 No If Yes, Give		1□ Yes 2⊠		T dono i nodin	0.0.,		ocify:	etc.	
8	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Itams 23a or 28a-f show ant, It e Medical Examiner must be notified at	ed b	15. Decedent's Educ	Year or Dates:	16a Decer	tent's Usual Oc	cupation		16		Cauc f Business/In	asian	
215	hin 72 8. 8n "ng	Completed	(Specify only highest grade	Completed) College (1-4or 5+)	(Give	kind of work do DO NDT use re	ne durina most	of working	, "	D. KIIIG O	(Dusiliess/III	dustry	
Maryland 21215-0036	ad with	Com	12	College (1-401-54)	Execu	tive As	ssistant			Elec	trical	-	
ng	be filk ital Hy id oth evant	Be	17. Father's Name (First, Middle, Last)					's Name (First	, Middle, Ma	iden Sun	name)		
<u> </u>	should ind Men s marka umatic	၀	Unknown	0.00			Unkn						
N N	O		19a. Informant's Name/Relationship (Type				eet and Number						70
ē,	s 1 and 3 f Health item 27 othar tr		Tony Cord / Person 20a. Method of Disposition	ar Kepresen 201	b. Place of Dispo	sition (Name of		Drive			on - City or To		79
altimore,	Pages nent of I ant: if it		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)		cemetery, cren t. Linco			/14/20	06 в	rent	wood,	MD	
a	permit. Departmine importa any injustra once.		21. Signature of Fune al Service Lorse				dress of Facility				-		
<u> </u>	8 2 E E 8		en Jen Ja	sch-) heere	1 1	J4U KOC	kville j	Pike; R	lockvi	lle,	MD 208	Senter 852	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause on each line.	_	er the mode of	dying, such as c	ardiac or resp	iratory arrest	t,		Approximate Interval Betw	/een
	Pnysician /Medical	H	Immediate Cause (Final disease or condition resulting in death)	SEPSI	15.							Onset and D	eatn
	Examiner			MAL NI		NOIT							
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons							-	-	
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	DECUPSI	SUFI	UL	CEN						
Ö,	The law requires that the death certificate be executed to has been signed by the attending physician and oage 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a cons									
09/8	physic physic the b	dlcal	d	INE	MUNI	-					-		
ox e	leath certific attending p I for use as	Physician/Me	IF FEMALE:	Bc. If yes, outcome of pre-	gnancy					204 1	Data of dalice		
ň	death a atter d for u	iciar	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 2☐F 4☐Pregnant at time of	etal death 3	Ectopic pregna Other (specify)					Date of delive Month		ear
J.	at the de by the stached	hys	9 Unknown	9□ Unknown									
	res that igned b	by F	Part II. Other significant conditions conf	ributing to death but not	resulting in the un	iderlying cause	given in Part I.	23	Be. Did tobac			e cause of de	
Records,	w require been sign	eted							1 ☐ Yes	2 (2) No	3 🗌 Prob	ably 4 □Un	known
ခိုင	The law cate has t page 2 s	Completed						24	a. Was an autopsy performer		b. Were autor prior to cor death?	osy findings av	/ailable use of
Vital		e Co	25. Was case referred to medical						Yes 2	No		2 00	
		0	examiner?	ospital: 1 Inpatient 2	ER/Outpatient	3 DOA	Other	of Death (Chec sing Home 5		a 6 🗆 C	thor (Specif	d	
10 0	ding Phys h. After this funeral di	T:uc	27. Manner of Death 1 Inatural 5 Pending	28a. Date of Injury (Month, Day Year,	28b. Time of	28c. ir	njury at Vork?		escribe how			7	
<u> </u>	eat or:	catlo	2 Accident investigation		,,,		□Yes 2□No	0					
DIVISION	or Ati	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - Al building, etc. (Spe	t home, farm, stre cify)	et, factory, office	ce	28f. Lo.	cation (Stree y or Town, S	t and Nui State)	mber or Rura	Route Number	9 <i>r</i> ,
_	spital ours a naral filled		29a. Certifier 1 Dertifying Physi	cian: To the best of my k	cnowledge death	occurred at the	time date and	place, and du	a to the caus	0/2) 224	mannar an at	nto d	
	To the Hospital or Attending within 24 hours after death. To the Funaral Director: After completely filled in by the fune completely filled in by the fune	edical	(Check only 2 Medical Examin one)	er: On the basis of exami and manner stated.	ination and/or inv	estigation, in m	y opinion, death	occurred at th	e time, date	and place	e, and due to	the cause(s)	
	To the within to the comp	ž	29b. Signature and title of certifier	Δ	UN	29c. Lice	ense number	~ <i>1</i>	29d.	Date sign	ned (Month, L	Day, Year)	
	5		> >> VI	guin,	417	10-	->42	84		13	120	O F	_
			30. Name and address of person who con	npleted cause of death (I	tem 23a) (Type, F	Print) AT	NEWIS	7 HO	SAIT A	12 7	Aum	un Pris	zn
	Sta	e	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	marke)		, , ,	- 11	H	D-70	2912	
	Registra	ar	JAN 12 2	008	11 19					•		1	į

			For State Registrar		-		lealth and	Mental Hygie	2005	43834
			1. Decedent's Name (First, Middle,	Last)				2. Date of Death		3. Time of Death
	Physicia /Medic		GEORGE LOUIS E	LLERS				Month December	Day Year 31, 200	
}	Examin		4a. Facility Name (If not institution,			4b. City, Town, o	or Location of Deat		4c. County of De	
			Doctor's Commu	nity Hospit	a1	Lanham			Prince (George's
	Funeral		5. Social Security Number		e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.			irthplace (State or Foreign
	Director		077-14-6782	1(XM 2□F	89 Yrs.	Williams Days	riours iviiri.	8. Date of Birth (Month, Day, Ye April 3,	1916 Ne	ew York
	pu ,		Usual Residence of Decedent		10.00					
	urylar show	_	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Ba-f.s	cto	Maryland Prince	George's	Greenbelt	t				1 X Yes 2 ☐ No
	or 21	Oire	10e. Street and Number			10f. Zip Code		10g.	Citizen of What (Country?
	23e	rai	13- H Hillside	Road		20770		U.	S.A.	
	tems	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	
36	s afte	γFi	1 Never Married 2 Marrie	If Yes, Give	10/5	1 ☐ Yes 2 ☑ No	Specify:			White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Mudical Examinat must be modified at	Completed by	3 Widowed 4 Divorced	Tear or Dates:	1945			1		
쟌	"nat	lete	15. Decedent's (Specify only highest	grade completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	oation during most of wor	rking 16b	. Kind of Busines	s/Industry
12	withir sne. than	ш	Elementary/Secondary (0-12)	College (1-4or 5)+)	writer Re				
2	Hygie ther int, I		17. Father's Name (First, Middle, L.	ast)	Туре	willer Ke		me (First, Middle, Maid	overnmer	IT.
an	od o	Be C	Louis Ellers	,					on barnamo,	
2	hould d Me mark matic	٢	19a. Informant's Name/Relationshi	n (Type Print)	19h Maili	na Address (Street	Mary W	alsti Iral Route Number, Cit	hi or Town State	Zin Codo)
Maryland	d 2 s th an 17 is trau	ı								
	1 an Heal em 2 ther		Pauline V. Ell 20a. Method of Disposition	ers - spous	20b. Place of Dispo	osition (Name of		reenbelt.	Mary Land Location - City o	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exartle at must be redified at once.		1 ☐ Burial 2 X Cremation			matory or other pla	1			
≣	it. P.		 4 □ Donation 5 □ Other (Special Service □ 21. Signature of Funeral Service □ 		Metropol:			asch's Fun		, Virginia
Ba	Depa Impo any ir	H,	21. Signatule of contanal services	CHISO				e., Hyatts		•
	2011	111	23a. Part I. Enter the disease, or c	1 /ac					ville, M	
	Pnysician /Medical Examiner		shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	a. Arterio:	sclerotic (a consequence of):					Approximate Interval Between Onset and Death Years
8760,	cate be executed physician and the burial-transit	ıl Examiner	Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	a consequence of): a consequence of):					
	physi s the t	edical	'	d						STREET, LANGUE DE LA CONTRACTOR DE LA CO
.O. Box 6	death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	у		23d. Date of do Month	elivery Day Year
<u>. </u>	law requires that the as been signed by th 2 should be detache	by PI	Part II. Other significant condition	s contributing to death b	ut not resulting in the u	inderlying cause giv	ven in Part I.	23e. Did tobacc	o use contribute	to the cause of death?
ecords,	quire n sign		Carcinoma Rect	um				1 🗆 Yes	2 □ No 3 □ F	robably 4 XUnknown
00	w require been sign	lete						24a. Was an	24b. Were a	utopsy findings available
Re	و ڪو	Completed						autopsy performed	prior to death?	completion of cause of
a	ician: Th certificate ector, pag	e C	25. Was case referred to medical				00 Pl (P	1 ☐ Yes 2 🔀	No 1 ☐ Ye	s 2 No
Vital		o B	examiner? 1 \(\sum \text{Yes} 2 \sum \text{No} \)	Hospital: 1 ☐ Inpatie	nt 2 X ER/Outpatier	ot 30 DOA Oth		ath (Check only one)	a [Tart - 10	
ion of	ding Afte fune	\vdash	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		of 28c. Injur Wor		lome 5 Residence 28d. Describe how in		эспу)
Division		Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At home, farm, sti c. (Specify)	reet, factory, office		28f. Location (Street City or Town, St		lural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in	edical	29a. Certifier 1 X Certifying (Check only one)	Physician: To the best xaminer: On the basis of and manner sta	examination and/or in	h occurred at the tir vestigation, in my o	me, date and place opinion, death occu	e, and due to the cause arred at the time, date a	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To the I within 2. To the I complet	Σ	29b. Signature and title of certifier	2011	20	29c. Licens	se number		Date signed (Mor	
)			1 Mance	andle		D01	852	JA	NUARRY	4,2006
0	10)11	1	30. Name and address of person w	ho completed cause of d	eath (Item 23a) (Type,	Print)				
4	9/1	q	Paul A. DeVore			Road, Hy	attsville	e, Maryland	20781	
	Sta Registr		JAN 0 9 20	2. Registra	ar's Signature					

			1 - State Registrar	State of Maryla	nd / Depa	artment of rtificate o	Health a f Death	and Mental I	Hygien Reg. N	Car Car	described and the second	38	35
	Physici	an	Decedent's Name (First, Middle, Last,					2. Date of Month	D	ay Y	ear	3. Time o	of Death
	/Medi		Mabel Emigholz					Decem		30, 20		3:55	РМ
	Examir	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town				c. County of			
_			Brighton Gardens 5. Social Security Number 6. Secur	7 400 //n //n	s. last birthday)	If Under 1 Ye	Chase			Montgo			
	Funeral Director			IM 267E	O Yrs.	Months Day		8. Date of (Month, Octob	Day, Yea er 3,	, 1915 I	Count	ace (State ry) esota	_
	land ow		10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10	d. Inside C	City Limits
	Many fied	ξ	Maryland Montgome	erv Ch	evy Cha	ise						1 🗌 Yes	2 ⊠ No
	r 288	Irec	10e. Street and Number		original designation of the second of the se	10f. Zip Code)		10g. C	itizen of Wh	at Count	rv?	
	h witi	ai D	5555 Friendship B1	.vd.		20815			U	ISA		,	
36	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23e or 28e-1 show any injury at other traumatic event, the Medical Examinat must be rotified at once.	by Funeral Director		12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give	'		f Hispanic Ori Joan, Mexican	gin? (Specify Yes or n, Puerto Rican, etc.)	_	14. Race -	White, e	tc.	
ô	hour tural	a pe	15. Decedent's Edu	Year or Dates:	16a Danie	de able Herrel O		-				ite	
5	in 72 "na kulic	Completed	(Specify only highest grade	e completed)	(Give	dent's Usual Occ kind of work dor DO NOT use reti	upation se during mosi md1	t of working	166.	Kind of Busir	ness/Ind	ustry	
7	with than	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	Homen	_	.00)		Ота	n Home			
ō	Hyg other ent,	Be C	17. Father's Name (First, Middle, Last)		Homen	arci	18. Mothe	er's Name (First, Mid			-		
<u>a</u>	lid be kad kad	To B	Carl Herbert Sand	strom			Mar	en Anders	en	,			
Maryland 21215-0036	shound N		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	ng Address (Stre	et and Numbe	or or Rural Route Nui	mber, City	or Town, Sta	te, Zip (Code)	
	and 2 aith a 127 li		Kenneth Emigholz	/ Son				Chevy Cha					
or c	item		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other p	(ace)	Date	20c. L	_ocation - Cit	y or Tov	n, State	
Ĕ	Page nent c		1 ☐ Burial 2 【XCremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)					-10-2006	Br	entwoo	d. I	Marv1	and
Baltimore,	permif. Departn Imports any injk		21. Signature of Funer Service Louise		Si	Name and Add	ress of Facility	Funeral an	nd Cr	ematic	n Co	enter	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the dea	ath. Do not ente	er the mode of d	ving, such as	Pike; Rock	v arrest,	e, <u>MD</u>		Approxima	te
2	Physician		Immediate Cause (Final									Interval Bel Onset and	Death
	/Medical		disease or condition resulting in death)	Inanition Due to (or as a conse	quence of):						1	lonth	<u>s</u>
	Examiner			Dementia	,,,,,,,							lears	
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):							cars	
	cutec nd ransi	Examiner	cause. Enter Underlying Cause (Slesses or injury) that initiated events								-1		
ó	e axe ian ai urial-t	EX	resulting in death) Last	Due to (or as a conse	quence of):							-	
68760	ificate be axecuted g physician and as the burial-transit	edical											
_	± ore	Med	IF FEMALE:										-
Вох	death certifi e attending id for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet	al death 3 🗌	Ectopic pregnan	су			23d. Date of			V
O	0 0 0	/sic	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4□Pregnant at time of a 9□Unknown	death 5□	Other (specify)			-	Month	L	ay '	Year
പ്	that fl		Part II. Other significant conditions con	tributing to death but not re-	sulting in the un	dorhiog cauco c	ivos is Bart I	220 Di	d tobassa				44-0
Vital Records,	requires that the een signed by th hould be detache	d by	, <u></u>	incurring to doubt but not 18.	solding in the di	derlying cause g	iveii ii raiti.			use contribu			
S	> 9 10	lete						-					
Ř	e la has je 2	Completed						24a. Wi	as an topsy rformed?	24b. Weri prior deat	to comp	y findings pletion of c	available ause of
<u>e</u>		e Co	25. Was case referred to medical					1 ☐ Yes	2 🖾 No		Yes 2	□ No	
	Physician: this certific ral director,	o Be	examiner?	ospital:	7500			of Death (Check only		- A	ssi	ste1	
o	r this aral dir	⊢ ,	27. Manner of Death	28a. Date of Injury	28b. Time of	3LI DOA	4 LI Nur	sing Home 5 Re			specify)	stel Livi	ng
0	th. : After funer	tior	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Inju	ork?]Yes 2 ∐ N		o non inju	ny occurred			
Division of	Hospital or Attending 24 hours after death. Funeral Director: After fely filled in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre fy)			28f. Location	(Street ar own, State	nd Number o. e)	r Rural F	Route Num	ber,
	Hospi 4 hou Funer ely fill	edical C	29a. Certifier (Check only one) 1 ☑ Certifying Phys 2 ☐ Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the estigation, in my	ime, date and opinion, death	place, and due to the control occurred at the time	e cause(s) and manne d place, and	r as stat	ed. ne cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licer	se number		29d. Da	te signed (M	onth, Da	y, Year)	
	λ .		1-0.00	c (0 su)	est	D394	56					,	
- [U	+	30. Name and address of person who cor	mpleted cause of death (Iter	m 23a) (Tuna P		,00		01/	05/20	Jo		
			Lila McConnell, M.			-	1400 •	Chevy Cha	Se N	m 208	15		
	, Sta	e	31. Date filed (Month, Day, Year)	32. Registrar's Signa				onevy ona	JE, M	ш ZUO.	L J		
	Registra	_	164 10 2009	_ /SF /S	ature Local	Se la la la la la la la la la la la la la							

			For State		State of M	aryland / D	-	irtment of l <i>tificate of</i>				(U	05	43836
			1. Decedent's Name	e (First Middle La	st)		Cei	uncate of	Dealli		. Date of Dea	eg. No.		3. Time of Death
	Physicia	an		Fedinick	.,						Month Decembe	Day	Year 2005	2:50 PM M
	/Medic				e street and number)			4b. City, Town,	or Location		Decemb		ty of Death	2.50 FM
	Examin	er		witcher (•	idena				Arund	le1
	Funeral		5. Social Security N			ge (In yrs. last birtl	hday)	If Under 1 Year	If Under	24 Hrs. 8	Date of Birth (Month, Day			place (State or Foreign
	Director		190-03-6	587	M 2□F	89 Y	rs.	Months Days	Hours	Min.	4ar 13	1916	Penn	sylvania
	P _		Usual Residence of	Decedent		140.00. =								
	show	_	10a. State	10b. County		10c. City, Town	or Loc	cation					1	0d. Inside City Limits
	Ba-f	cto	MD	Anne Ar	undel	Pasa	adei							1 ☐ Yes 2 ☐ No
	or 2	Director	10e. Street and Nu					10f. Zip Code	0110	0		0g. Citizen o		ntry?
	23e	ra		itcher Co	T	Consideration of the constant	40.14	1 - 2	2112		4		USA	an India
	er de Item	nue	11. Marital Status		12. Was Decedent)	13. V	Vas Decedent of Yes, specify Cub	Hispanic Ori Jan, Mexicar	n, Puerto Ri	ty Yes of No- can, etc.)		ace - Americ ack, White,	
36	rs aft	Jy F	1 ☐ Never Marr	ied 2 ☐ Married 4 ☐ Divorced	1X Yes 2 ☐ If Yes, Give Year or Dates:	*37 - 67	1	☐ Yes 2 No	Specify:	:		Spec	<i>ify:</i> whi	te
21215-0036	72 hours after death with the Maryland 'naturel', or Items 23s or 28s-f show dical Examiner must be notified at	Completed by Funeral	K	15. Decedent's Ed	1	16a.	Deced	ent's Usual Occu	pation			16b. Kind of	Business/In	dustry
115	n "ne	piet	(Spec	cify only highest gra	de completed) College (1-4or		(Give I	kind of work done OO NOT use retire	during mos	st of working	7			,
212	filed within Hygiene. other then "	E O	12	moary (0°12)	0		ef	Master :	Sargea	int		U.S.	Air H	Torce
b	il Hygie other	ВеС	17. Father's Name	(First, Middle, Last)							First, Middle,			
lar	Mental Mental arked o	ToE	Mike	Fedinik					Ann	na Kaz	ibroda			
Maryland	2 should and Men Is marke aumatic		19a. Informant's N	ame/Relationship (Type, Print)	19b.	Mailin	g Address (Stree	t and Numbe	er or Rural I	Route Number	r, City or Tow	n, State, Zip	Code)
	1 and 2 Health a lem 27 ls		Linda Ma	son/daugh	nter	55	9 D	owitcher	Cour	t Pas	adena,	MD 21	1122	
ore.	ges 1 and 2 should be filed within 72 hours after death with the Marylan t of Health and Mental Hygiene. If item 27 is marked other then "naturel", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Dis	'	Removal from State	cametan	Dispos /, crem	sition (Name of natory or other pla	ice)	Dat	19	20c. Location	- City or To	own, State
Ĕ	Pa ant:		`4 ∏Donation	5 Other (Specif	y)									
Baltimore,	permit. Pages 1 and: Department of Health Importent: If Item 27 any injury or other tr		21. Signatur 1 Fu	uneral Service Licer anald S.		ector		Name and Addr		Soard 21201	655 W.	Balti	nore S	Street
			23a. Part1. Enter t	he disease, or com	plications that cause one cause on each I	d the death. Do n		.1timore			espiratory arr	est,		Approximate
	Di etetek		Immediate Cause	(Final	one cause on each I	ato ad	PINA	carcino	00.74					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	on /	a	a consequence o		arario	1100					
	Examiner				Die to (or as	a consequence o	ч).						1	
		ē	Sequentially list co if any, leading to it cause. Enter Unde Cause (Disease or	inditions,	b. Due to (or as	a consequence o	0:							
	uted d ansit	Examiner	Cause (Disease or that initiated events	injury	C									
o,	exec en an rial-tr	Exa	resulting in death)	Last	Due to (or as	a consequence o	f):							
68760,	ficate be executed physicien and s the burial-transit	edical			_ d									
	artific ing p		IF FEMALE:											
Вох	death certifi attending I d for use as	lan/	23b. Was deceden			2 Fetal death		Ectopic pregnand	y			1	ate of delive	Day Year
	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/M	1 ☐ Yes 2 î 9 ☐ Unknown	□No	4□Pregnant a 9□Unknown	t time of death	5 🗌	Other (specify) _						,
P.0	that the by detail		Part II. Other signi	ficant conditions of	ontributing to death t	out not resulting in	the un	iderlying cause g	ven in Part I	l.	23e. Did to	bacco use co	ntribute to th	ne cause of death?
of Vital Records,	uires sign ld be	Completed by	Cena	1 Failu	(ન <u>ે</u>						1□Y	es 2 No	3 🗆 Prob	ably 4 Unknown
00	w req beer shou	lete									24a. Was a	n 24b	Were auto	psy findings available
Re	sician: The law scertificate has b lirector, page 2 s	duc									autops	med?	prior to con death?	mpletion of cause of
a			25. Was case refer	rred to medical					26 Place	a of Death (1 ☐ Yes Check only or		1 🗆 Yes	2 No
5	Physician: r this certific ral director.	o Be	examiner? 1 ☐ Yes 2 🔀		Hospital:	ent 2 ☐ ER/Out	patient	3□ DOA Ot	hor		5 Resid	_	ther (Snecif	-
of	Phy er this	n:T	27. Manner of Deat	th	28a. Date of Inju	ury 28b. T	me of	28c. Inju			d. Describe h			,,
on	Attending in death.	atlo	1 KNatural 2 ☐ Accident	5 Pending investigation		iy reary	ijury		Yes 2	No				
Division	Atte er des ecto by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	250. Place of in	jury - At home, far tc. (Specify)	m, stre	et, factory, office		28	f. Location (S. City or Town	treet and Nun	ber or Rura	l Route Number,
	rs after or rs after or relation of the second of the second or relation or relation o	Cer												
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only one)		nysician: To the best niner: On the basis of and manner st	of examination and								
	To the To the To the Complex c	Me	290. Signature and	title of certifier		2		29c. Licen	se number		2	9d. Date sign	ed (Month,	Day, Year)
}			E IIM	41011	Medical	Vactor		D	451	48		Janua.	4,17	, 2006
			30. Name add	ress of person who	completed cause of	death (Item 23a) (Туре	Print))	1	1,	7)	4'	1-
	Sta	to	31. Date filed (Mon	th, Day, Year)	10 3708 32 Regist	Mounta rar's Signature	nk	1000	10500	Xony,	1741	ytan	4 21	122
	Sta Registi		11	IN 2 6 201	16	A B. A.	100	Bes.						

State of Maryland / Department of Health and Mental Hygier® 0.05

L	3	8	3	
	- 40"	-		

5	Physician /Medical Examiner

Funeral

Director permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health end Mental Hygiene. Important: if Item 27 le marked other then "naturel", or Items 23a or 28s-f show eny injury or other traumatic event, the Medical Exacultant numbbe notified at once.

Baltimore, Maryland 21215-0036

ysician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attanding physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	1 - For State Registrer	otato of marytane		tificate of L		<u> </u>		ig. No.	40001
	Decedent's Name (First, Middle, Last)		-				Date of Deat		3. Time of Death
n al	EDDIE	HARRISON						r 17,2005	12:00 P M
r	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of D			4c. County of Dea	
	Holy Cross Hospita	1		Silver	Sprin	ıg		Montgome	ry
	5. Social Security Number 6. Sex	M SELE		If Under 1 Year Months Days	If Under 24 H	Ain. (rthplace (State or Foreign ountry)
	579-38-2157 Usual Residence of Decedent	74	Yrs.			S	eptemb	er 11, Rid	geway, S.C.
	10a. State 10b. County	10c. City	, Town or Loc	ation					10d. Inside City Limits
ţō	District of Columb	ia Was!	hingto	n					1 ☐ Yes 2 ☐ No XX
ě	10e. Street and Number			10f. Zip Code			10	0g. Citizen of What C	ountry?
<u>a</u>	900 Varney Street	SE #326		20032			U	nited Star	tes
an Tue	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	5. 13. W	Vas Decedent of His Yes, specify Cubar	spanic Origin? n, Mexican, Pi	? (Specify uerto Rica	Yes or No- n, etc.)	14. Race - Am Black, Whi	
by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:	1	☐ Yes 2√√ No	Specify:			Specify:	Black
eted	15. Decedent's Educ (Specify only highest grade		(Giva I	ent's Usual Occupa	uring most of	working		16b. Kind of Business	s/industry
Be Completed	Elementary/Secondary (0-12) Twe 1 th	College (1-4or 5+)	life. D	OO NOT use retired)	, ,		1		f Columbia
ပ္ပ	17. Father's Name (First, Middle, Last)		secr	etary	18. Mother's	Name (Fir		Maiden Sumame)	of Education
To Be	Robert Harrison Sr							nningham	
-	19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Mailin	g Address (Street a				City or Town, State,	Zip Code)
	Veronica Jackson/D	aughter	1117	Kennebec	St #4D	,0xo	n Hill	,Maryland	20745
	20a. Method of Disposition		ace of Dispos	sition (Name of natory or other place	Dec	Date cembe	r 28,	20c. Location - City o	r Town, State
	DOBurial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	Ft Ft		ln Cemete	ry 20	005	1	Brentwood	Mary land
	21. Signature of Funeral Service License	Mason Fune Lngton DC							
	23a. Part1. Enter the disease, or complishock, or heart failure. List only on	*	Approximate						
	shock, or heart failure. List only on Immediate Cause (Final		Interval Between Onset and Death						
	disease or condition resulting in death)	Foot Gangre Due to (or as a consequence)							
		Due to (or as a consequ	ence or).						
Jer	Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience of):						
E	that initiated events	:							
edical Examiner	resulting in death) Last	Due to (or as a consequ	ience of):						
lica		ł							
5	IF FEMALE:	20 16							
ian	in the past 12 months?	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy				23d. Date of de Month	elivery Day Year
Completed by Physician/I	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown	aun S_	Other (specify)					
γP	Part II. Other significant conditions con	tributing to death but not resu	ulting in the un	derlying cause give	en in Part I.		23e. Did tob	pacco use contribute	to the cause of death?
ed b	End Stage Renal D	isease				_	1 □ Y€	es 2.	robably 4 Unknown
piet							24a. Was a	n 24b. Were a	autopsy findings available
ĕ							autops perform		
Be (25. Was case referred to medical examiner?				26. Place of				
2	1 ☐ Yes 2 ☐ No		ER/Outpatien		4 LINUISII	ng Home	5 🗆 Reside	ence 6 Other (Sp	ecify)
on:	27. Manner of Death 12 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work			Describe ho	ow injury occurred	
cat	2 Accident investigation 3 Suicide 6 Could not be	00 81			Yes 2 □ No	-			
it it	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office		281.	City or Town	reet and Number or F n, State)	Hurai Houte Number,
Š	29a. Certifier 1 X Certifying Phys	sician: To the best of my know	wledge death	occurred at the tim	no date and n	lace and	due to the c	auco(c) and manner	ac clated
Medical Certification;		ner: On the basis of examinat and manner stated.	tion and/or inv	estigation, in my of	pinion, death o	occurred a	t the time, d	ate and place, and du	ue to the cause(s)
Σ	29b. Signature and title of certifier	> (/		29c. License			2	9d. Date signed (Mor	
	1	X		D2657	Τ.			December	20,2005
	30. Name and address of person who co Sarah Bromeland, 1				nring	Morest	land o	0910	
te	21 Date filed (Minth Mayo Very)	000		DITAGE D	hrring	iiai y l	Lailu Z	0)10	
ar	31. Date filed (Majny, party ear) 200	6 Mis Come A		18.1					

Sta

State of Maryland / Department of Health and Mental Hygier)e | | 43838 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** EUGENE HUNTER CHARLES DECEMBER 30 2005 7:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 13107 JERVIS STREET CLINTON PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 948 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□F Yrs Director 579-64-2024 WASHINGTON, DC Usual Residence of Decedent with the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show the Medical Examiner - ust be notified at 1 X Yes 2 □ No Directo PRINCE GEORGE'S MD CLINTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 13107 JERVIS STREET Itams 23a 20735 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ੴ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify BLACK 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE BUS DRIVER 12th other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be factor of Health and Mental Fint: If Itam 27 is marked of ANNA MAE LEWIS CHARLES HUNTER To 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13107 JARVIS STREET CLINTON, MARYLAND 20735 YOLANDA A. HUNTER/WIFE othar 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from Sta permit. Page Department of Important: If any injury or once. RESURRECTION CEMETERY 1/6/2006 CLINTON, MARYLAND * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligansee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 13 7474 LANDOVER ROAD LANDPVER, MARYLAND 20785 Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final METASTASIS LUNG CANCER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Box 68760 Physician/Medical d as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the a 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ peq PULMONARY TUBERCULOSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an DIABETES MELLITUS TYPE II has page 2 autopsy performed? certificate 21 No 1 Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 Tyes 2 **X**No 1 Inpatient 4 ☐ Nursing Home 5 € Residence 6 ☐ Other (Specify) C 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After or Attanding 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. filled in by determined 4 | Homicide City or Town, State) within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number ္ရ 555 uguer 10 D28079 January 5, 2006 30. Name and address of person who completed cause of death (Irem 23a) (Type, Print) 11700 Beltsville DRIVE # 100 BELTSVILLE, MARYLAND 20705 FRANCINE SHIPMAN M.D. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JAN 0 9 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene, 43839 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 29, 2005 **Physician** December 2:15 P M Hubert Montague Hackney /Medical 4c. County of Deeth 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mariner Health Bethesda Bethesda Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Dey, Year) 04/20/1922 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthdav) 5. Social Security Number **Funeral** Days 1√2 M 2 □ F 244-18-8220 83 N. Carolina Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City, Town or Location 10a, State r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 □ No Gaithersburg Montgomery Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 394 North Summit Avenue 20877 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No 11 Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8 th College (1-4or 5+) Warehouse Manager Private permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If tem 27 Is marked othe say injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Allen Hackney Elizabeth Montague 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracy V. Hackney - Daughter 310 Lincoln Avenue; Rockville, MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crematory 01/11/2006 Riverdale, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Freeman Funeral Services endanytruna P.O.Box 416; Suitland, Maryland 20752 23a. Pert Enter the disease, or corr shock, or heart failure. List only omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 2 No 3 Probably 4 Unknown 1 TYes page 2 should Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 20 No certificate 1 ☐ Yes 2 ☐ No 1 Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) \$ No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? After Hospital or Attending 5 Pending investigation Natural М 1 Yes 2 No death. 2 Accident filled in by the hours after deal uneral Director: 6 Could not be determined 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 2 00023256 Sanson 8, 9000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Caracaton, mo rald Read 4 1 0 2006 2. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

JC 05-UN Steph

-07	456		Please T	ype or Print in Black	Inc	lelible Ink	. Ensure	All Copie	s Are	Legible.	
K hen	Li		1 - For State Registrar	State of Maryland / D		rtment of tificate of		Mental H	ygien Reg. N	6002	43840
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Stephen Li					2. Date of I Month Novemb	er 0	5, 2005	3. Time of Death 14:10 P M
	Examin Funeral Director	ier	4a. Facility Name (If not institution, give s Washington Adventis 5. Social Security Number unk 6. Sex 157	st Hospital 7. Age (In yrs. last birth	$\overline{}$	Takoma If Under 1 Year Months Days	If Under 24 Hrs	8. Date of E	M Sav. Year	9. Birti	ry County replace (State or Foreign unitry) unk
Maryland	fahow	tor	Usuel Residence of Decedent 10a. State unk 10b. County	unk 10c. City, Town	or Loc	ation			-	unk	10d. Inside City Limits unk, [Yes 2] No
h with the	23a or 28a at be notifi	ai Director	10e. Street and Number	ι	ınk	10f. Zip Code		unk	10g. Ci	itizen of What Co	untry? un
d 21215-0036 filed within 72 hours after death with the Maryland	ital Hygiene. id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status unk 1 Never Married 2 Married 3 Widowed 4 Divorced	I2. Was Decedent Ever in U.S. Armed Forces? unk 1 □Yes 2□No If Yes, Give Year or Dates:		/as Decedent of Yes, specify Cut ☐ Yes 2∏ No	Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yes or to to Rican, etc.)	10-	14. Race - Ame Black, White Specify: a	
21215-0036	than "natur	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) unk ur	College (1-4or 5+)	Give k	ent's Usual Occu kind of work done O NOT use retire	during most of wo	_{rking} unk	16b. F	Kind of Business/	ndustry unk
/land 2	d d	To Be Co	unk ur 17. Father's Name (First, Middle, Last)	IK.		unk	18. Mother's Na	me (First, Midd	e, Maider	n Sumame)	unk
Baltimore, Maryland Dermit, Pages 1 and 2 should be file	of Health Item 27 r other tr		19a. Informant's Name/Relationship (Ty) O.C.M.E. 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R	20b. Place of cemetery	1 1 Dispos	enn Str	tand Number or R		D 2	or Town, State, 2 212()1 ocation - City or	
Baltin permit. P.	Department Important: If eny Injury or once.		4 Donation 5 10 Other (Specify) 21. Signature of Euneral Project License	ade Director			ess of Facility Tomy Boa		W . Ba	altimore	Street
1	nysician Medical xaminer		23a. Part1. Enter the disease, or complishock, on eart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do not e cause on each line. Atheroscierofic. Due to (or as a consequence of	cunc	r the mode of dy	ing, such as cardia	c or respiratory			Approximate Interval Between Onset and Death
/60, te be executed		cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of							
.O. Box 68/ the death certificate	hed by the attending physic detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnanc Other <i>(specify)</i> _	y			23d. Date of deli Month	very Day Year
J E		þ	Part II. Other significant conditions con	tributing to death but not resulting in	the un	derlying cause gr	ven in Part I.		tobacco		the cause of death?
		Completed						24a. Wa aut per 1 Yes	s an opsy formed? 2 \(No	24b. Were aut prior to c death? 1 X Yes	opsy findings available ompletion of cause of 2 No
VICIAL IICIAL	certif	Be	25. Was case referred to medical examiner?	ospital:		10:	26. Place of Dea				
Phys Call distribution	th. : After this s funeral di	ıtlon: To	1 → Yes 2 → No 27. Manner of Death 1 D Natural 5 → Pending 2 → Accident investigation	28a. Date of Injury 28b. Ti	_	28c. Inju	4 🗆 Nuising r	lome 5 ☐ Res 28d. Describe		6 □Other (Spec ry occurred	ıfy)
UNISION Ital or Attending Its after death. ral Director: Afte		Certification:	3 Suicide 6 Could not be 4 Homicide determined	n, stre	et, factory, office			(Street ar own, State		ral Route Number,	
the Hosp	hin 24 hou the Funer mpletely fil	Medical	(Check only 2 Medical Examin	ician: To the best of my knowledge, ler: On the basis of examination and and manner stated.	death or inve	estigation, in my	me, date and place opinion, death occurse number	o, and Jee to the urred at the time	, date and	d place, and due	to the cause(s)
<u>د</u>	T CO		29b. Signature and title of certifier	mis		0.C.N		:		ite signed <i>(Month</i> nber 06,	
	<u> </u>		30. Name and address of person who co	m. 0 111 Per	nn i	Street,	Baltimor	e, Mary	land	21201	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 6 2008	32. Registrar's Signature	224	W					

December Well Moths Lass Replace December December Replace			-	For State Registrar	State of Man		artment of H		Mental Hygie	ene 0 0 5	43841
HENRY MANUEL LESSER One of the significant of control of the significant of the signific										Day Your	3. Time of Death
## 1 Seal Private Control County Control County Control				HENRY MANUEL LESSE	:R				_		2:47 A M
Montgomery General Title	e-ij					· · · · · · · · · · · · · · · · · · ·	4b. City, Town, or	Location of Dea	ith	4c. County of Death	
Signature Sign	П			Montgomery General			Olney			Montgomer	У
State The County The State The State The County The County		Funeral							(Month, Day, Y	(ear) 9. Birth	place (State or Foreign
The Sales Tot County Tot County Tot County Tot County Tot County Tot County Total States Tota		Director		3/9-20-3188	KM 2LIF 8	31 Yrs.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		May 3 19.		
Aaron Samuel Lesser 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 2ste. Name and Address of Principles (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Name Predictional (Crope, Pring) 1ste. Name Predictional (Crope, Pring) 1st. Informational (Crope, Pring) 1st		pu *	}		11	Oc City Town or L	ncation			1	I Od. Inside City Limits
Aaron Samuel Lesser 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 2ste. Name and Address of Principles (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Name Predictional (Crope, Pring) 1ste. Name Predictional (Crope, Pring) 1st. Informational (Crope, Pring) 1st		eho	ក								
Aaron Samuel Lesser 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 2ste. Name and Address of Principles (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Name Predictional (Crope, Pring) 1ste. Name Predictional (Crope, Pring) 1st. Informational (Crope, Pring) 1st		he N	ect		nery	Silver			100	Citizen of What Cou	ntry?
Aaron Samuel Lesser 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 2ste. Name and Address of Principles (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Name Predictional (Crope, Pring) 1ste. Name Predictional (Crope, Pring) 1st. Informational (Crope, Pring) 1st		with	ā		rala #207						,
Aaron Samuel Lesser 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 2ste. Name and Address of Principles (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Name Predictional (Crope, Pring) 1ste. Name Predictional (Crope, Pring) 1st. Informational (Crope, Pring) 1st		ns 23	era		12. Was Decedent Eve	er in U.S. 13.	Was Decedent of H	ispanic Origin? (Specify Yes or No-		
Aaron Samuel Lesser 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 2ste. Name and Address of Principles (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Name Predictional (Crope, Pring) 1ste. Name Predictional (Crope, Pring) 1st. Informational (Crope, Pring) 1st		fter d	표	Tr. Maria Glara	Armed Forces?		If Yes, specify Cuba	in, Mexican, Pue	erto Rican, etc.)	TTL	
Aaron Samuel Lesser 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 2ste. Name and Address of Principles (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Name Predictional (Crope, Pring) 1ste. Name Predictional (Crope, Pring) 1st. Informational (Crope, Pring) 1st	99	urs a	by		If Yes, Give Year or Dates: W	W-II	1 ☐ Yes 2 ② No	Specify:		Specify: WII	rte
Aaron Samuel Lesser 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 2ste. Name and Address of Principles (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Name Predictional (Crope, Pring) 1ste. Name Predictional (Crope, Pring) 1st. Informational (Crope, Pring) 1st	Ō	72 ho	ted	15. Decedent's Edu	cation	16a, Dece	dent's Usual Occup	ation	orking 16	6b. Kind of Business/In	dustry
Aaron Samuel Lesser 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 2ste. Name and Address of Principles (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Name Predictional (Crope, Pring) 1ste. Name Predictional (Crope, Pring) 1st. Informational (Crope, Pring) 1st	21	thin 7	nple			life.	DO NOT use retired	1)		- 1 1 0	
Aaron Samuel Lesser 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Mailing Address (Simet and Number or Plusia Review Number, Crypt or Town, State, 2p Oxes) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 2ste. Name and Address of Principles (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Informaris Name Predictional (Crope, Pring) 1ste. Name Predictional (Crope, Pring) 1ste. Name Predictional (Crope, Pring) 1st. Informational (Crope, Pring) 1st	2	ed wi	Sol		5+	Accou	ntant				vernment
20. Mented of Deposition Duris 20. Mented of Deposition Comments 20. Mented of Deposition Duris 20. Comments 20. Mented of Deposition Duris 20. Comments 20. Mented of Deposition Duris 20. Comments 20. Mented of Deposition Duris 20. Comments 20. Mented of Deposition Duris 20. Comments 20. Mented Duris 20. Comments 20. Mented Duris 20. Mented Duris 20. Mented Duris 20. Mented Duris 20. Mented Duris Duris 20. Mented Duris D	n	~ ~ 0 %	0								
20. Mented of Deposition Duris 20. Mented of Deposition Comments 20. Mented of Deposition Duris 20. Comments 20. Mented of Deposition Duris 20. Comments 20. Mented of Deposition Duris 20. Comments 20. Mented of Deposition Duris 20. Comments 20. Mented of Deposition Duris 20. Comments 20. Mented Duris 20. Comments 20. Mented Duris 20. Mented Duris 20. Mented Duris 20. Mented Duris 20. Mented Duris Duris 20. Mented Duris D	<u>yla</u>	Men Arke	၉								
Approach of Disposition Date 20c. Lecation - City or Town, State Brentwood, MD 21. Signatury of Pureral Service Licenses Pt. Lincoln Crematory of Part Date Brentwood, MD 22. Signatury of Pureral Service Licenses Pt. Lincoln Crematory of Part Date Brentwood, MD 23. Signatury of Pureral Service Licenses Date Da	Jar	2 sh and le m		1 1 2	•						
Provision (Medical Examiner) Provision (Medical Examiner)	ē,	Health tem 27									
Provision (Medical Examiner) Provision (Medical Examiner)	Ö	age in age			emoval from State				31-2005 B	rentwood	MD
Provision (Medical Examiner) Provision (Medical Examiner)		artm orter injur			99	2	2. Name and Addres	ss of FacilityH-1	nes-Rinald	i Funeral	Home, Inc.
Provision (Medical Examiner) Provision (Medical Examiner)	Ba	Dep my any		Imanda Sh	udours)						
Proyection (Pacific Cause (Final disease or condition resulting in death) Sequentially is conditions. If any, heading is conditions, If any, heading is con				23a. Part1. Enter the disease, or compli	cations that caused th						Approximate
Companies Discontinuity Discontinuity Discontinuity		Charleton .		Immediate Cause (Final	0	intocti.	ral Hou	AMMA	ner D		Onset and Death
State State Sequentially list conditions Due to (or as a consequence of): d. Due to (or as a consequenc					1	consequence of);	uct beh	TOVAM	ay t		
The part of the past of the pa	В	Examiner									
Due to (or as a consequence of): Due to (or as a consequence of):			ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a c	onsequence of):					
State		cuted nd ransi	ami	that initiated events							
State	Ö,	e exe ian a urial-	Ä	resulting in death) Last	Due to (or as a c	consequence of):					
FEMALE 23c. If yes, outcome of pregnancy 1 ive birth 2 Fetal death 2 Fetal death 2 Fetal death 3 Fetal death 5 Other (specify)	876	ate the	dica		J						
25. Was case referred to medical examiner? 10	9	entific ling p	Me.	IF FEMALE:	2a If you guttoome of	D/AGDADOV				004 0-4-44-6	
25. Was case referred to medical examiner? 10	BO	ath c	lan/	23b. was decedent pregnant	1 Live birth 2	Fetal death 3		1			/
25. Was case referred to medical examiner? 10	<u>.</u>	the a	ysic	1 ☐ Yes 2 Sto		ne or death 5	_ Other (specify)				
25. Was case referred to medical examiner? 10	٦.	hat the	Ph		ntributing to death but	not resulting in the	underlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	he cause of death?
25. Was case referred to medical examiner? 10	ds,	signe bed		3	•		, , ,		1 ☐ Yes	2 □ No 3 □ Pro	bably Doknown
25. Was case referred to medical examiner? 10	00.0	requ	etec						24- 146	24h Wasa aut	and findings qualible
25. Was case referred to medical examiner? 10	3ec	e faw has I je 2 s	Id III						autopsy	prior to co	empletion of cause of
27. Manner of Death Continuous Special Continuo	a	r. Th							1 ☐ Yes 21		2000
27. Manner of Death Continuous Special Continuo	Zi.	ricien certif recto	00	examiner?	lospital:		Oth	OF.			***
State Stat	of	Phys this ral dii		T Tes No	inpatient		III 3 DOA	4 Nursing			fy)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hotthew M. Avolve 18 101 Prince Milip Drive 0 (Mey MD 20832) State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	UC	After After fune	tle	1 Natural 5 ☐ Pending	(Month, Day Y		Wor	k?		,,	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hotthew M. Avolve 18 101 Prince Milip Drive 0 (Mey MD 20832) State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	isi	deati deati ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	/ - At home, farm, s	treet, factory, office		28f. Location (Stre	et and Number or Rur	al Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hotthew M. Avolve 18 101 Prince Milip Drive 0 (Mey MD 20832) State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	<u>S</u>	after after I Dire	erti	4 Homicide	building, etc.	(Specify)			City or Town,	State)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hotthew M. Avolve 18 101 Prince Milip Drive 0 (Mey MD 20832) State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		Hospite 4 hours Funere ely fille		(Check only 2 Medical Exami	ner : On the basis of e	xamination and/or i	th occurred at the tir nvestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the cau	ise(s) and manner as a	stated. to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hotthew M. Avolve 18 101 Prince Milip Drive 0 (Mey MD 20832) State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		the I	Med		and manner state	d.	29c Licens	e number	290	d. Date signed (Menth.	Day, Year)
State 31. Date filed (Month, Day, Year) 32 Registrar's Signature		5 × 5 0		296. Signature and offering Certifier	^ ~	MX	Do	1210	(2/15/20	
State 31. Date filed (Month, Day, Year) 32/Registrar's Signature	7	4		Imman		110	In	10017	0 1	4000)
State 10 2000 Las A Pagado				Mathew McAVO	ompleted cause of dea	III (Item 23a) (Type	co Mili	p Drive	c Olner	MD 208	32
						s Signature	realis				

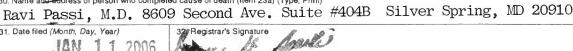
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 8:15PM M Albert December 30,2005 Lafayette /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Shady Grove Nursing & Rehabilitation Ctr. Montgomery Rockville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** <u>₩</u>м 2□ F Days Hours 256-20-2768 Yrs. Director 12,1924 Savanah, Georgia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ehow r than "natural", or Iteme 23a or 28a-f eho: The Medical Examinar must by ricitified at 1 X Yes 2 ☐ No Funeral Director MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701 Medical Center Drive 20850 United States filed within 72 hours after death 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Be Completed by 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry United States Office Of Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Chemist Covert Management permit. Pages 1 and 2 should be filed v Depertment of Health and Mental Hygie Important: If item 27 is marked other it eny injury or other traumatic event. Las 4 vears 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert Simms Lafayette Lottie E. Cargile 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louisa Lockette/ Sister 45 Blue Spruce CT. Lumberton, New Jersey 08048 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Howard Medical School 12/20/05 Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Austin Royster Funeral Home 3821 14th Street NW Washington, DC 20011 6 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rean failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 2 years Cardiac Arrhythmia /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and Il-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physicien a s the burial-P.O. Box 68760. Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Gangrene Legs, Peripheral Vascular Disease. 1 Tes 2 No 3√ Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No perform 243 No 1 🗌 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 XNursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) JAN 11 2006



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D28656

January 05, 2006

amend 5-22 per F.H. ,27,30 per Dr. g850 12/14/05 KBH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. g850 12/29/05 State of Maryland / Department of Health and Mental Hygiene 0 0 5 amend 3 per Dr. 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. 0745 ath **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MEDICAL CENTERLA PLATA CHARLES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number UNL 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□M 2 F Director MD 8/24/05 Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, it. Medical Examinar must be notified at MD Director prince George Ft. Washington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Doris Dr. 20744 USA Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 0 infant infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Timothy Moore Alexis Patrice Collier 19a. Informant's Name/Relationship (Type, Print) mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other tra Alexis Patrice Collier 8800 Doris Dr. 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield- Echols 9/1/05 Charlotte Hall, MD. 22. Name and Address of Facility 211 St. Mary's Ave. 21. Signature of Funeral Service Licensee 20646 Arehart-Echols Funeral Home, P.A. David C. Echols (perDVR) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical D e to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 2 XNo 1 Yes 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death Check only one examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient = 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A investigation М 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner spated. 29a. Certifier Medical completely (Chack only one) the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who con eted cause of death (Item 23a) (Type, Print) Dr. Zelleke 701 E. Charles ST. LaPlata , Md. 20646 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar	State of M	Marylan		artment rtificate			and M		giene Reg. No.	005	43841	e culture la culture l
	Physici	an	1. Decedent's Name (First, M								2. Date of Dea	/ Day	Year	3. Time of Deat	
	/Medic Examin	al	4a. Facility Hame (If not institu	Magne V	er)		1		Location o	of Death	Decem	4c. 0	5, 200 County of De	ath	
				Regional Ho				uure		24 Hrs.				George's	
	Funeral Director		5. Social Security Number 230–50–6435	6. Sex 7 1 M 2 □ F	Age (In yrs.)	last birthday) Yrs.	If Under Months	Days	If Under: Hours	Min.	8. Date of Birt (Month, Da Aug. 5,	1942	Vi	irthplace (State or Ford Sountry) rginia	эign
	D		Usual Residence of Decedent 10a. State 10b. Cou		10c Cit	y, Town or Lo	ocation							10d, Inside City Lin	nite
	Maryla a-f sho	tor	VA Fair		Ale	xandria								1 ☐ Yes 2 X ☐	
	h with the 23e or 28s	Funeral Director	10e. Street and Number 7854 Audubon Ave	e .			10f. Zip 2230					10g. Citiz USA	en of What (Country?	
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "neturel", or items 23e or 28e-f show any injury or other traumatic event. Its Medical Exam har must be notified at once.	b	11. Marital Status 1 □ Never Married 2[X] 3 □ Widowed 4 □ Divor	It Yes, Give	^{」№} Vi∈	s. 13. et Nam			spanic Orion, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	1	Black, Wh	nerican Indian, pite, etc. White	
21215-0036	within 72 h ane. than "netu	Completed	15. Dece (Specify only hi Elementary/Secondary (0-1 12	dent's Education ghest grade completed) 2) College (1-4c)	or 5+)	(Give	dent's Usua kind of wor DO NOT us Setter	k done d	u <i>rina</i> mosi	t of worki	ng		d of Busines tructio		
land 2	S should be filed with and Mental Hygiene. Is marked other than aumatic event, the Mental Brown of the Men	To Be Co	17. Father's Name (First, Mid Harvey Elijah M						18. Mothe Marg	er's Name aret 1	(First Middle Brioget E	Maiden S Olton	Surname)		
Maryland	1 and 2 shou Health and M Iem 27 Is mar other traumati	-	19a. Informant's Name/Relat Patricia K. Hes			19b. Mailii 7854	ng Address Audubar	(Street a	nd Numbe , Ale	or or Rura	ia, VA 22	er, City or 2306	Town, State	Zip Code)	
Baltimore,	Pages 1 a nent of Hee int: If item iry or othe		20a. Method of Disposition 14 Burial 2 Cremati 4 Donation 5 Other	on 3 □Removal from Sta r (Specify)	20b. Poti	Place of Disponentery, creational Me	osition (Nam matory or ot MOICLAL	e of Pank	p)		, 2005	20c. Loc Falls	ation - City of Church	or Town, State VA	
Balti	permit, Pages Department of Important: If it any injury or o		21. Signate of Juneral Service Control			53	2. Name and	d Addres Click	s of Facilit	y Da Sprin	maine Fur gfield, V	A 221	Harre 51		
8760,	Examiner Cate be executed Ca	icai Examiner	23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	n line.	uence of): H a uence of):		5 OI GYIIIS	, 3001 43	cardiac	п өзрпасогу а	irost,		Approximate Interval Between Onset and Death	
O. Box 68	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnanin the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnan 9 □ Unknowr	n 2 ∏ Feta tat time of d	Ideath 3	⊒Ectopic pre ⊒ Other (spe					23	3d. Date of d Month	elivery Day Year	
rds, P.	quires that in signed by	by	Part II. Other significant con	ditions contributing to deat	h but not res	ulting in the u	inderlying ca	ause give	n in Part I		23e. Did to			to the cause of death	
Records,	siclan: The law requir s certificate has been si lirector, page 2 should I	Completed											24b. Were prior to death?	autopsy findings availa completion of cause as 2 No	able of
Vital	clan: ertifica ector, p	Bec	25. Was case referred to me examiner?					12.		of Death	(Check only o	one)			
of	ding Physiclan: h. After this certifica funeral director,	1.	1 Yes 2 No	Hospital:		ER/Outpatie		other Review	4 NU		me 5 Resid			ecify)	_
O	Jing J. After fune	ition	1 ☑ Natural 5 ☐ Pe	28a. Date of I (Month, restigation	Day Year)	Injury	м	8c. Injury Work 1 🔲 ۱	? ′es 2 [∷		2001. 20001.20	now injury	00001100		
Division	al or Attendi after death. I Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Co	termined 28e. Place of building.	Injury - At he etc. (Specif	ome, farm, st	reet, factory	, office			28f. Location (S City or Tox		Number or i	Rural Route Number,	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edicai	29a. Certifier 1 Cert (Check only 2 Med	ifying Physician: To the be ical Examiner: On the basic and manner	s of examina	owledge, deat tion and/or in	th occurred anvestigation,	at the tim in my op	e, date an inion, dea	d place, th occurr	and due to the ed at the time,	cause(s) a date and p	and manner place, and d	as stated. ue to the cause(s)	
),	Tot	Σ	29b. Signature and title of ce	riffier /	5	e		License	53	23	5	12	16/	ngh, Day, Year)	
1)		30. Name and address of per	so complete we d		n 23a) (Type,	Print) Ra	1	in	re	A	ven	ve	Lamet	0
	Sta Regist		31. Date filed (Month, Day, Y	1 107	istrar's Signa		anti)					•			

the Maryland

Pages 1 and 2 should be filed within 72 hours after deeth

The law requires that the death certificate be executed

Box 68760.

o

Records, P.

of Vital

6

Hospital

Baltimore, Maryland 21215-0036

Amend item#28a-1, petr E, 051, 1/23/06 11

Amend item#28a-1, petr E, 051, 1/23/06 11

State of Maryland / Department of Health and Mental Hygiene 1 5 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 18, 2005 **Physician** 5:45 A M KENNETH MC CLINTON L. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Hospital Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | APR . 12 , 1973 | MARYLAND 5. Social Security Number UNF 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 10XM 2□ F Director 32 Yrs Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral', or Items 23a or 28a-f shore Examiner must be notified at MD. Director 1 ☐ Yes 2 ☐ No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4400 FURLEY AVENUE 21206 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1X Never Married 2 Married **BLACK** 1 ☐ Yes 2 No by 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry r than " Elementary/Secondary (0-12) College (1-4or 5+) 11THUNEMPLOYED NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental is marked KENNETH MCCLINTON, SR. ၉ JOAN DEAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is
any injury or other trau KENNETH MC CLINTON, SR. (father) 4400 FURLEY AVE. BALTO, MD. 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Conation 5 ☐ Other (Specify) GREEN MOUNT CREMATORY JAN. 28, 2006 BALTO, MD. gnature of Funeral Service Licensee 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. PALTO, MD. 23a. Part1. Enter the disease, or complications that caused the disease, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Smoke inhalation and thermal injuries complicated by cocaine intoxication Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Due to (or as a consequence of) Examine physicien and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as ettending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetel death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death Day signed by the el d be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? tv∑vyes 2 No 1√2√Yes : After this certific a funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1.XXVes 2 ☐ No Certification: To Fnd 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending death. 4:53 A М 1 ☐ Yes 2 🎇 No investigation 2 Accident Dec. 18, 2005 House fire and drug use Director: d in by the €CCould not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 3226 Brendle Court filled in by 4 Homicide To the Hospital within 24 hours e vacant house Baltimore, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Commenced Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 19, 2005 30. Name and ad person who compared cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

Pamela E. Southall, MD 111 Penn Street, Baltimore, Maryland 32 Registrar's Signature

		-	For State Registra WEND#26perM	State of M 01/10/06,BMW,N	aryland 1600	/ Depa	rtment of H tificate of I	ealth and Death		giene Reg No.	005	43846
	Physici /Medic		Decedent's Name (First, Middle, MAJID MAS	Last) SUMI					2. Date of De Month DECEMBEI		2005 Year	3. Time of Death 11:00 PM
2	Examin	er	4a. Facility Name (If not institution, 1312 GATESHEAD ROA 5. Social Security Number	D	ge (In yrs. las	t birthday)	4b. City, Town, or TOWSON If Under 1 Year	If Under 24 Hrs	8 Date of Big	B th	SALTIMORE 9. Birthpl	ace (State or Foreign
	Funeral Director		215-98-8815 Usual Residence of Decedent	1፟፟M 2□F	82	Yrs.	Months Days	Hours Min.	(Month, Da 4/25/19	19, Year) 923	IRAN	try)
	Maryland -f show fled at	tor	10a. State 10b. County MARYLAND MONTGOM	ERY	10c. City, BET	Town or Lo CHESDA	cation				10	0d. Inside City Limits 1 ☐ Yes 2∑ No
	h with the 3a or 28a st be nuti	Funeral Director	10e. Street and Number 6774 SURREYWOOD LA	NE	-		10f. Zip Code 20817			10g. Citize	en of What Coun	try?
036	I within 72 hours after death with the Maryland liene. I than "natural", or Items 23a or 28a-f show I the Medical Examination must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☒ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' d 1 Tyes 2 Till If Yes, Give Year or Dates:	?	1	Vas Decedent of Hi f Yes, specify Cuba I ☐ Yes 2Ã No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		Race - America Black, White, e	etc.
Maryland 21215-0036	within lene. r than "	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)			(Give	lent's Usual Occupa kind of work done of OO NDT use retired ER	furing most of wo	orking		of Business/Ind	
land ;		To Be C	17. Father's Name (First, Middle, L HASSAN MASSUMI	,				18. Mother's Na TARAB	me (First, Middle MASSUM		umame)	
Mary	es 1 and 2 should b of Health and Ment fitem 27 is marked ir other traumatice		19a. Informant's Name/Relationshi NAZZI NAZERI/DAUGH				g Address (Street a			er, City or 7	Town, State, Zip	Code)
45	Pages 1 an nent of Heal int: If item 2 iry or other	- Constant	20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 1 △ Donation 5 □ Other (Special Control of the Control	3 □Removal from State	'	e of Disponetery, crem	sition (Name of natory or other plac MORIAL PARI	e)	Date 51/2005		ation - City or To	wn, State
Balti	permit. Pages 1 Department of H Important: If itel any Injury or ott		21. Signature of Funeral Service Li		'		. Name and Addres		1800 NEW I			.0904
68760,	ilicate be executed B physician and Street burial-Iransit B the burial-Iransit	edical Examiner	23a. Part1. Enter the disease, or on shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter the conditions of the cause of t	a. CARDI Due to (or as b. Due to (or as C. ATHER	ine. AC ARRE a consequent ARY ART a consequent ROSCLERO a consequent	ST nce of): ERY DI nce of): SIS						Interval Between Onset and Death
O. Box 68	law requires that the death certifica as been signed by the attending ph 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal de	eath 3	Ectopic pregnancy Other (specify)			236	d. Date of deliver	ry Day Year
۵.	uires that t signed by ild be detac	by	Part II. Other significant condition	s contributing to death	but not resulti	ng in the u	nderlying cause give	en in Part I.		obacco use		e cause of death?
al Records,	The ate his page	Completed							1 Yes	psy ormed? 2 1 No	24b. Were autop prior to con death? 1 \(\text{Yes}	psy findings available inpletion of cause of 2 No
ion of Vital	ing Phya After this uneral di	atlon: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending investigs		ury 2	VOutpatien 8b. Time of Injury	28c. Injury Work	er: 4 🗆 Nursing l	ath (Check only of the Home 6 12 Rose 28d. Describe	dence 6	S TESTO Control	ence -
Division	al or Attendi s after death. Il Director: A od in by the fu	Certification:	3 Suicide 6 Could no determine	280. Place of It	iury - At homitc. (Specify)	e, farm, str	eet, factory, office		28f. Location (City or To	Street and I wn, State)	Number or Rural	Route Number,
	To the Hospital or Atta within 24 hours after de . To the Funeral Directo completely filled in by th	edical	29a. Certifier I	Physicien: To the best xaminer: On the basis of and manner s	of examination	edge, deat! n and/or in	occurred at the time restigation, in my of	ne, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) ar date and pl	nd manner as sta lace, and due to	ated. the cause(s)
,	To within	W	29b. Signature and title of certifier	3	5	7	29c. License	328	31	29d. Date s	signed (Month, D	ay, Year)
	1		30. Name and address of person w	to completed cause of	death from 2	3a) (Type, SW)	Print)	67855	MILLIO,	713	2/201	4° Zeo
	Sta Regist		31. Date filed (Month, Day, Year)	38 Regist	rar's Signatur	fie	de)					

CPM 05-08556 Brenda McCauley

aa	McCaule	₃y	1 - For State Registrar	State of Mar	yland / Dep	artme				ital Hygie	/ 11	05	43847
			Hegistrar Decedent's Name (First, Middle, Last)			Timod	10 01 1	Jean	2	Heg Date of Death	J. No.		3. Time of Death
н	Physicia	an	Brenda McCauley							Month	Day	Year	
	/Medic		4a. Facility Name (If not institution, give s	treet and number)		4b Cit	/ Town or	Location of De		cember		2005 ty of Death	12:10 P ^M
ń	Examin	er			1 Contor		altim		- Catti		10. 000.	., 0. 000	
	Funeral		Johns Hopkins Bayva 5. Social Security Number 6. Sex		(In yrs. last birthday,	If Und	er 1 Year	If Under 24 h	Hrs. 8.	Date of Birth Month, Day, Y		9. Birthp	place (State or Foreign
	Funeral Director		220-66-6452	^{M 2} √2 F 5		Month:	Days	Hours M		Month, Day, Y			rginia
	9		Usual Residence of Decedent						1110				
	how	_	10a. State 10b. County		10c. City, Town or L	ocation						1	0d. Inside City Limits
	Ba-f e	cto	Maryland Baltim	ore			Dun	dalk					1 ☐ Yes 2, ☐ No
	ith th	Dire	10e. Street and Number	3 1 5		10f. Z	ip Code	04000		100		f What Cour	ntry?
	ath v	by Funeral Director	7303 Dunwall Court					21222				SA	
	er de litem	nue		12. Was Decedent Ev Armed Forces?	rer in U.S. 13.	Was Dec If Yes, sp	edent of Hi ecify Cuba	spanic Origin? n, Mexican, Pu	? (Specify uerto Rica	Yes or No- in, etc.)		ace - Americ ack, White,	
36	rs aft	γF	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∐ Yes 2√∑√No If Yes, Give Year or Dates:		1 🗆 Yes	2 X No	Specify:			Spec	ify: Wh	nite
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or iteme 23e or 28e-f ehow In Mudical Exams nat must be notified at	ed	15, Decedent's Educ	ation	16a. Dece	dent's Us	ual Occupa	ition		16	Sb. Kind of	Business/In	
15	n n	Completed	(Specify only highest grade	completed)	(Give	kind of v	rork done d use retired	luring most of	working				
212	iane r the	E	12	College (1-4or 5+)	,	I	N/A				N	/A	
	il Hygir other	Se C	17. Father's Name (First, Middle, Last)					18. Mother's I	Name (Fi	rst, Middle, Ma	iden Suma	ите)	
<u>a</u>	ould be Mental Marked o	To Be	Rodger McCauley					Wi	illa	Taylor			
Maryland	E E E	-	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Maili	ng Addre	ss (Street a	and Number or	r Rural Ro	ute Number, (City or Town	n, State, Zip	Code)
	and 2 raith a 127 is		Willa Sauer/mothe	er	1	94 C	ampus	Green	Driv	e Arı	nold,	MD 2	21012
Baltimore,	of He of He fiten		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R	amount from State	20b. Place of Disponentery, cre	osition (N	ame of other plac	9)	Date	20	c. Location	- City or To	wn, State
Ĕ	Pages nent of ant: If it ury or o		4 □ Donation 5 □ Other (Specify)	amovar from State	Jakemont	Mem	. Gar	dens 1	1/10/	2006 I	David	sonvil	le, MD
alt	Dapartr Importe eny inju	1 3	21. Signature of Funeral Salvice License	· 4111	2	2. Name	and Addres	s of Facility	John	M. Tay	lor Fi	uneral	. Home
<u>m</u>	80 = 9	9	Toda E.	dill									MD 21401
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) 5a. United list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e cause on each line. Athorosc Due to (or as a				ac du		•			Approximate Interval Between Onset and Death
68760,	tificate be executed ig physicien and as the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a o	consequence of):								
O. Box	death cer e ettendir d for use	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 W Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal death 3	Ectopic Other	pregnancy specify)					ate of delive	ory Day Year
rds, P.	requires thet the een signed by th nould be detache		Part II. Other significant conditions con	tributing to death but	not resulting in the t	nderlying	cause give	on in Part I.			cco use cor	ntribute to th 3 ☐ Prob	ne cause of death? ably 4 Unknown
al Records,	The lay ate has page 2	Completed							-	24a. Was an autopsy performe 1 Yes 2		prior to cor	psy findings available inpletion of cause of 2 No
Vital	ding Physician: h. After this certific funeral director.	Be	25. Was case referred to medical examiner?	ospital:			Otho		Death (Ch	eck only one)			
to	Phys this al dir	5	1XXYes 2 No 27. Manner of Death	I 🗀 Inpatient				4 14015111		5 Residence			/)
ū	ا ق ق م	<u>6</u>	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	Year) 280. Time o	M	28c, Injury Work		280.	Describe how	injury occu	irred	
Division	or Atten after deat Director: in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, st (Specify)			∕es 2□No		Location (Stre City or Town,		ber or Rura	l Route Number,
_	Hospital 24 hours a Funeral etely filled	Medical C	29a. Certifier (Check only one) Check only one) Check only one)	ician: To the best of tar: On the basis of eard manner state	xamination and/or in	h occurre vestigation	d at the time on, in my op	e, date and pli inion, death o	lace, and o occurred a	due to the caust the time, date	se(s) and n	nanner as st	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			2	9c. License	number		290	I. Date sign	ed (Month,	Day, Year)
	->-0		Jan HAK will.	11 nes			\cap	.C.M.E.		D	ecemb	er 19	2005
			30. Name and address of person who co	mpleted cause of dea	ith (Item 23a) (Tyna	Print)							
			Pamela E. Lonx	hail MI			Stre	et, Bal	ltimo	re, Ma	rylan	1 2120)1
	Sta	te	31. Date filed (Month, Day, Year)	32. Pigistrar	s Signature	_					-		
	Registr	ar	JAN 1 0 20	06	W K	best							

Gregory Miles Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#21a,PII,27,penHE,0352,2/1/06 II
State of Maryland / Department of Health and Mental Hygiene 05-08144 NJM 1 - For State Ragistrar Certificate of Death Reg No 1 Decedent's Name (First Middle Last) 2. Date of Death Month Day Ves **Physician** 2005 December 0814 Gregory Thurston Miles /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Oeath Examiner Salisbury Peninsula Regional Medical Center Wicomico If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Oct. 8, 1958 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□F Director 220-68-8237 Md. Usuel Residence of Decedent Manyland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show item 27 ie marked other then "natural", or iteme 23a or 28a-f shov other treumatic event, in a Madical Exaction must be notified at Md. 1X Yes 2 □ No Somerset Princess Anne Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21853 11667 Beckford drive USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. illed within 72 hours after 1 Never Married 2 Married timore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Disabled Not Working 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Miles Ernest Η. Elouise Hayman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Beckford dr. Princess Anne, Md. 21853 Gloria Hudson / Sister 11667 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ŏ Department of tmportant: If eny injury or John Wesley Ceme. 12/09/05 Princess Anne, Md. 22. Name and Address of Facility Bennie Smith Funeral Home 21. Signature of Funeral Service Licensee 30479 Prince William st. Princess Anne, Md. 21853 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypertensive Cardiovascular Disease Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disa to for as a nonsequence of) Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, physicien Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ed by the a detached f signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by Seizure Disorder 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should 24a. Was an autopsy ⊸penform 24b. Were autopsy findings available prior to completion of cause of death?

123-Yes 2□ No 2 No Yes Hospital or Attending Physicien: 25. Was case referred to medical funeral director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 1 Ves 2 No Other: ٩ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA his 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification; 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death
To the Funeret Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the th

٥ 3 State

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of cartifier

31. Date filed (Month)

JACK JAN 3 0

Mitih M.D. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

29c. License number

OCME

111 Penn Street

29d. Date signed (Month, Day, Year)

December, 5, 2005

Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene 43849 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Payton 0143 Cecelia Louise /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner tilegani nwber 16ar Birthplace (State or Foreign Country) If Under 1 Year If Under 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min 1 ☐ M 2 🖾 F 100 Director 215-18-8025 04/02/1905 Pennsylvania Usual Residence of Decedent death with the Manyland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23s or 28s-f show the Medical Examinar must be notified at 11 Yes 2 □ No MD Allegany Cumber land Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1110 Frederick Street 21502 USA Funera Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemak er 6 Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Francis Aloysious Bittlebrum Sarah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at important: if item 27 is any injury or other traconce. Lucille McIntyre / niece 1110 Frederick Street, Cumberland, Maryland 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State S.S. Peter & Paul Cem. 4 ☐ Donation 5 ☐ Other (Specify) 12/31/2005 Cumberland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, Maryland 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DMYJ CRA Due to (or as a consequence of) /Medical Examiner Bury Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury mone Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ned by the atter 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 ☑ No Day Y*e*ar Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 WUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death Injury at Work? After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident efter death Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral (1 Standard Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Oay, Year) 29b. Signature and title of certifier 29c. License number DECEMBIN 04205 2 erson who completed cause of death (Item 23a) (Type, Print) Cumberland MD 21502 NOB 410 R. GreGG 32. Registrar's Signature 31. Date filed (Month, Oay, Year) State Registrar DEC 3 0 2005

Lee Roy Ruby UNK 05-05798 dl

d1			1 - For State Registrar	State of M	aryland		artment ortificate			ind M		giene Reg. No.	005	438	50
			Decedent's Name (First, Middle, L.)	ast)							2. Date of Dea	ath		3. Time of	Death
	Physici		LEE	ROY		RUI	BY				Month August	28.	2005	1:18	РМ
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)			4b. City, To	wn, or Lo	ocation o	f Death			County of Dea		
-			woods near 692 M	Maritime Bl	vd.			nthi					ne Aru		
	Funeral		5. Social Security Number 6. 214-44-5151	Sex 7. Ag		ast birthday) Yrs.	If Under 1 Months [f Under 2 Hours	Min.	8. Date of Birt (Month, Day	h v. Ye <i>ar)</i>	9. Bir	thplace (State o ountry)	
	Director		Usual Residence of Decedent		60	, 113.					6-19-19	43			MD
	/land		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside C	ity Limits
	Man	tor	MD UNKNO	NMO		UNKI	NOWN							1 🗆 Yes	2 □ No
	or 284	Director	10e. Street and Number				10f. Zip C					10g. Citiz	zen of What C	ountry?	
	within 72 hours after death with the Maryland ene. than "naturel", or lieme 23e or 28e-f show he Medical Examinat must be notilled at	ral	UNKNO						NOWN				USA		
	er de	Funeral	11. Marital Status	12. Was Decedent Amed Forces?	?	S. 13.	Was Deceder If Yes, specify	t of Hisp Cuban,	anic Orig Mexican	gin? (Spec , Puerto F	offy Yes or No- Rican, etc.)	' '	14. Race - Ame Black, Whi		
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ∑ Yes 2 ☐ If Yes, Give Year or Dates:	NO		1□Yes XI	ON C	Specify:				Specify: W	HITE	
21215-0036	2 hou	edt	15. Decedent's	Education	-	16a. Dece	dent's Usual (Occupation	on			16b. Kir	nd of Business	/Industry	
715	hin 72 in "na Medi	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or	5+)	(Give life.	kind of work DO NOT use	done duri retir e d)	ring most	of workin	g	т	EWELRY		
7	or tha	Com	10	H-V	,		MAI	NAGEI							
2	d oth	Be (17. Father's Name (First, Middle, Las	_				18			(First, Middle,				
<u>ya</u>	Meni Meni Marke	2		Ruby		T				VELYN			HEARTY		
Maryland	12 sh and is m		19a. Informant's Name/Relationship Evelyn Charlene T		ster						Route Number				
e,	1 and Health em 27 ther 1		20a. Method of Disposition	- Cliffey / B1	20b. PI	lace of Dispo	sition (Name	of	ide i		ate		cation - City or		
ПŌГ	ages nt of l t: # It		1 Burial 2 ☐ Cremation 3		ÇE	emetery, crer	natory or other Cemet	er place)		2/17/	2006			.11e, MI)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel; or Iteme 23a or 28a-1 show any injury or other treumatic event, the Medical Examiner must be notified at Appe.		21. Signature of Funeral Service Lice	ensee n		22		_			gleton			-	
Ba	Depa Impo any I		buna I alles	Va C M	01364	1	Second	l Ave	e SW	$, G1\epsilon$	en Burn	ie M	D 2106	le r.A.	
F			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause	d the death	. Do not ent	er the mode o	of dying,	such as	cardiac or	respiratory ar	rest,		Approximat Interval Bet	e ween
	Physician	8 8	Immediate Cause (Final disease or condition	•		nt 100	ound.	to H	Leac	1				Onset and	Death
	/Medical		resulting in death)	Due to (or as				10 11		•					
	Examiner	L	Sequentially list conditions,	b											
V	be sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):									
7	and and II-tran	хап	that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):									
68760,	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	calE	· ·												
687	ificate g phy: as the														
Вох	death certifica e attending ph id for use as th	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			∃Ectopic preg	nancy				2	3d. Date of de		
. 8	deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a			Other (spec						Month	Day `	Year
P.O.	at the	Physician/Med	9 Unknown			41: 1- Al-	- 4 4		·- D. 41		22 Did to			o the cause of c	de edb 2
Ś	The law requires that the ate has been signed by th page 2 should be detache	þ	Part II. Other significant conditions	contributing to death t	out not resu	uting in the u	nderiying cau	se given	ın Part I.		23€. Did (0	1	E.	robably 4 🗆	
Record	requi	Completed					**					/			
3ec	e law has t	ldm									24a. Was autop	sy		utopsy findings completion of c	
<u>a</u>	n: Th licate r, pag											med? 20 No	1 ☐ Yes	2 □ No	
Vital	siciar certifirecto	Be	25. Was case referred to medical examiner?	Hospital:		ER/Outpatier	2 7 704	Other:			(Check only o		S F Other (Co.	and anon	20
ō	Physic this aral di	. To	1 XYes 2 No 27. Manner of Death	1 ☐ Inpati	IIIV	28b. Time of		Injury at Work?	4 🗆 1901		ne 5 ☐ Resid 8d. Describe h			cify) SCEI	ie
Ö	Attending r death. ector: After by the funer	atlor	1 □ Natural 5 □ Pending 2 □ Accident investigati	on Found,	ay Year)	Frynd	PM		s 2 💢	No	Subj	ect	-shot	5016	
Division	Atte	fle	3 Suicide 6 □ Could not 4 □ Homicide determine	be 28e. Place of In		me, farm, str	eet, factory, o	office		2	8f. Location (S	treet and	Number or A Beken	ural Route Num	iber,
Ö	rs afte	Certification;				in wo	oods				62 Ha	ritim	e Blird	Linthicu	im MD
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	(Check only 2 Medical Ex	Physician: To the best aminer: On the basis of	of examinat	wledge, deatl tion and/or in	h occurred at vestigation, in	the time, my opin	date and	d place, a th occurre	nd due to the d d at the time, d	ause(s) date and	and manner a place, and du	s stated. e to the cause(s	s)
	the I	Medi	29b. Signature and title of certifier	and manner st	tated.			icense n					signed (Mon		
)	T wil		OI A A	Nanon	111	nd									
7	2		30. Name and address of person wh	o completed cause of	death (Item	23a) /Tuna		C.M.	<u>.</u> E		August 29, 2005				
	3		CAROL H. A	WHA) WA	A COUNTY OF THE PARTY OF THE PA	. Lou) (19pe,		enn S	Stree	et, E	Baltimo	re,	Marylar	nd 21201	L
	Sta		31. Date filed (Month, Day, Year)	32. F. gist	rar's Signal	turk A									

			1 - For State Registrar	State of I	Marylar		artmen rtificat			ind M		giene Reg. No.	005	l.	3851
7	Physic /Medi Exami	cal	4a. Facility Name (If not institution, g	ETTE	er)		4b. City,	Town, or	Location o		2. Date of De Month	t 10	200 County of De	5	Time of Death 3:35 AM
	Funeral Director	368	NONE			last birthday) O Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Bird (Month, Da	y, Year)	_	Country)	(State or Foreign
	ith the Maryland or 28s-f show	Director	Usual Residence of Decedent 10a. State 10b. County MANULAND 10e. Street and Number			ity, Town or Lo			,			10a Citi	ten of What	1	nside City Limits Yes 2 □ No
36	after death w or items 23a	by Funeral Di	3050 ARUNI 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede	nt Ever in U	J.S. 13.		212 dent of Hi city Cuba		in? (Spe , Puerto F	cify Yes or No Rican, etc.)	- 1	4. Race - Ar Black, W	nerican Inchite, etc.	
d 21215-0036	be filed within 72 hours hall Hygiene. ed other than "natural", event, the Madical Exp	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 17. Father's Name (First, Middle, La.	Education trade completed) College (1-40		16a. Dece (Give life.	dent's Usua kind of wo DO NOT us ZN	rk done a se retired,	uring most		ng (First, Middle,	Z,	od of Busines		
e, Maryland	s 1 and 2 should be f Health and Mental item 27 is marked o other traumatic eve	To Be	TAYON TEN 19a. Informant's Name/Relationship KIMBERLY GOUG	(Type, Print)	HER)	19b. Mailir	OAK	RUN	KII nd Number AH A	nB or Rural VENU	ERLY Route Number	GO or, City or	UGH Town, State) 21216 XXLXXXD
Baltimore,	permit. Pages 1 Department of H Importent: If ite any Injury or otl ence.		20a. Method of Disposition 1	eify)	te		natory or o	CEM2 d Addres	Tery s of Facility med		OOB	BAL	TIMORI	m 719	ARYLAND
8760,	death certificate be executed A death certificate be executed by the certi	icai Examiner	23a Part1-Enter the disease, or co shock, or heart failure. List on Inmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or and or control of the		puence of):			, such as c	ardiac or	respiratory ar	rest,		Inter	oximate val Between at and Death
P.O. Box 68	che the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcon 1 ∐Live birth 4 ∐ Pregnant 9 ☐ Unknown	2 Fete	death 3	Ectopic pro					23	3d. Date of d Month	elivery Day	Year
	n requires that been signed should be de	Ď	Part II. Other significant conditions	contributing to death	but not res	ulting in the ur	nderlying ca	ause givei	n in Part I.		1 🗆 Y	es 2		Probably	4 Unknown
Vital Records,	ysician: The law is certificate has b director, page 2 st	Be Completed	25. Was case referred to medical examiner?						26. Place o	of Death	24a. Was a autops perform 1 Yes	med? 2 No	24b. Were a prior to death?	completio	dings available on of cause of
oţ	ding Phys h. After this funeral di	Certification; To I	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident 3 Suicide 6 Could not	ho	njury Day Year)	ER/Outpatient 28b. Time of Injury	M 21	A Other 8c. Injury Work 1 \(\text{Y}	4 🗆 Nurs	sing Hom	e 5 Reside	ence 6		ecify)	
Divi	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determined	building.	etc. (Specifi	y)	occurred :	at the time	, date and	place, ar	City or Town	n, State)	nd manage a	o stated	
)	To the H within 24 To the F complete	Medical	29b. Sign (toxe and title of certifier	man di manner	stated.	tion and/or inv	estigation,	. License	nion, death	occurrec	at the time, d	ate and p	signed (Mon	e to the ca	
50	Sta	te	30. Name and address of person who JEROME MAR. 31. Date filed (Month, Day, Year) JAN 2	AVE, M.E	death (fter 76 strar's Signa	01 0	SLEX		CIVE	70	Wsow	m	HRYL	AND	21204
4	Registr	ar	JAN 2	2006	ALGERAL .	A Pa									

		For State Registrar 1. Decedent's Name (First, Middle, La			icate of Deat		Reg. No.	3. Time of Death				
Physic /Med		TIA DENI	SE RICKS			OCTOBE!	10 2005					
Exami		4a. Facility Name (If not institution, giv			. City, Town, or Location		4c. County of E					
	- <u>120</u>	ST. JOSEPH ME 5. Social Security Number 6. S			Tows Under 1 Year If Und			TMORE Birthplace (State or Forei				
Funeral Director	4		□ M 2 XF	O Yrs. Mc	onths Days Hour	ler 24 Hrs. s Min. 3 2. (Month, Da		Birthplace (State or Forei Country) MARYLAND				
how		10a. State 10b. County		ity, Town or Location		,		10d. Inside City Limi				
the Marylar 28a-f ehow	cto	naryland	4		RE CITY			1 Yes 2 □ N				
with the	Dire	10e. Street and Number	ALCOTAGE		0f. Zip Code 21210		10g. Citizen of What					
ns 23	eral	3050 ARUN 11. Marital Status	12. Was Decedent Ever in I			Origin? (Specify Yes or No		merican Indian,				
72 hours after deeth with the Maryland "natural", or items 23a or 28a-f ehow olical Examinar must be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1	If Ye	s, specify Cuban, Mexi Yes 2 No <i>Spec</i>	can, Puerto Rican, etc.)	Black, V	White, etc. BLACK				
72 ho	eted	15. Decedent's E	ducation ade completed)	16a. Decedent'	s Usual Occupation of work done during m	nost of working	16b. Kind of Busine	ess/Industry				
	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO N	NOT use retired)	g	INFA	NT				
illed v Il Hygie other ti	S	17. Father's Name (First, Middle, Last		11		other's Name (First, Middle						
ental l ked ol ic eve	9 Be	TAVON TERK		Ka		im BERLY	Gough					
inar mat	2	19a. Informant's Name/Relationship (nber or Rural Route Numb		e, Zip Code) 212 16				
alth ar 27 is r trau		KIMBERLY GOL	GH (MOTHER			AVENUE BA						
of Hee		20a. Method of Disposition		Place of Disposition cemetery, cremato	n (Name of ry or other place)	Date	20c. Location - City	or Town, State				
nit. Peges partment of loortant: if it injury or o		1 Aburial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) The property of other place) Apall 26, Baltimore Holy REDETMER Centify 2006 MARYLE										
permit. Peg Department Important: any injury o		21. Signature of Euneral Service Live	1588	22. Na	me and Address of Fa	EDICAL CE	NTER	21204				
205 2		23a. Part1. Enter the disease, or com	-	76	OI OSLER	DRIVE TOW	SON, MAR	Approximate				
Medical Examiner Asicien and burial-transit	cal Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse	equence of):								
that the death certificate I hed by the ettending physis detached for use as the b	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Pel 4 Pregnant at time of 9 Unknown	tal death 3 Ect	opic pregnancy ner (specify)		23d. Date of Month	delivery Day Year				
s that the ned by th e detache	y Ph	Part II, Dther significant conditions	contributing to death but not re	sulting in the under	lying cause given in Pa	nt I. 23e. Did t	obacco use contribut	e to the cause of death?				
w requires that been signed to should be det						1 🗆	Yes 2 No 3	Probably 4 Unknow				
The la ete hes pege 2	Completed					24a. Was auto peric 1 □ Yes						
ician: Th certificete rector, peg	Be	25. Was case referred to medicat examiner?	Uganitali			ace of Death (Check only	one)					
Physician: this certific ral director,	5	1 Yes 2 No 27. Manner of Death				Nursing Home 5 Resi		Specify)				
D 0 0	Certification;	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b			28c. Injury at Work? VI 1 Yes 2	how injury occurred	r Rural Route Number.					
To the Hospital or Attendin within 24 hours efter death. To the Funeral Director: Att completely filled in by the fur		4 Homicide determined	28e. Place of Injury - At I building, etc. (Specingsician: To the best of my kr			City or To	wn, State)					
24 hc 24 hc Fun etely	edical	(Check only 2 Medical Examone)	miner: On the basis of examinand manner stated.	nation and/or investi	gation, in my opinion, o	death occurred at the time,	date and place, and	due to the cause(s)				
To the Vithin To the Complex C	Me	29b. Signature and title of certifier	1 0-		29c. License numbe		29d. Date signed (M					
•		Jeany ho	1 maran	_	D210	60	10/10/	05				
								-				
		30. Name and address of person who JEROME MARAY	completed cause of death (Ite	em 23a) (Type, Prin	Deive	Towson,	magail	ارد مرد الله				

DHMH 17 Rev 1/2001

State Registrar

George W. Stickley
Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760,

	1 - State Registrer		epartment of F Certificate of I		Reg. No	1000 45655				
cian lical	Decedent's Name (First, Middle, Last) George Warn		Stickley	De	ate of Death onth Da	2005 11:35 al				
iner I	5. Social Security Number 6. Sex 1 ★ 218-30-9688	ing Hom	e Boons	If Under 24 Hrs. 8. Da Hours Min. (M		c. County of Death Uashing ton 9. Birthfulce (State or Foreig Country) Maryland				
٦.	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limit: 1 ☐ Yes 2 [X] No				
al Director	MD Allegany 10e. Street and Number 10101 Stickley Road		Flintstone 10f. Zip Code 21	530	10g. Cit	tizen of What Country?				
by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 1 □ Was Deca Armed For 1 □ Yes 1 □ Yes	2 <u>K</u>) No	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	spanic Origin? (Specify Y n, Mexican, Puerto Rican, Specify:	es or No- , etc.)	14. Race - American Indian, Black, White, etc. Specify: White				
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1		Decedent's Usual Occupi Give kind of work done of life. DO NOT use retired Farmer	during most of working	16b. K	Kind of Business/Industry				
Be	17. Father's Name (First, Middle, Last) James W.	Stick		18. Mother's Name (First	, <i>Middle, Maiden</i> Mae					
To	19a. Informant's Name/Relationship (Type, Print) Paul Stickley / son	19b. I	Mailing Address (Street a	and Number or Rural Rout	te Number, City o	Long or Town, State, Zip Code)				
	20a. Method of Disposition 1.XXBurial 2 Cremation 3 Removal from 5 4 Donation 5 Other (Specify) 21. Signature of Fureral Service Licenses	20b. Place of I cemetery	Disposition (Name of crematory or other place) Family Cemete 22. Name and Addres	ry 01/02/2006	20c. Lo F1 Family Fu	intstone, Maryland meral Home, P.A.				
edical Examiner	Sequentially liet conditions: if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	or as a consequence of	em Putton s a consequence of):							
Physiclan/Medl	in the past 12 months?	ome of pregna <i>n</i> cy th 2 Fetal death nt at time of death wn	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delivery Month Day Year				
b	Part II. Dther significant conditions contributing to de	ath but not resulting in t	he underlying cause give	on in Part I. 23		use contribute to the cause of death? ☐ No 3 ☐ Probably 4 ★ nknow				
e Completed					la. Was an autopsy performed?	24b. Were autopsy findings availab prior to completion of cause of death? 1 ☐ Yes 2 ☐ No				
ertification; To B	27. Manner of Death 1 Alatural 5 Pending investigation 3 Suicide 6 Could not be determined	patient 2 ER/Outp	me of 28c. Injury Work	'es 2 □ No 28f. Lo	Residence escribe how injur	ry occurred and Number or Rural Route Number,				
edical C	29a. Certifier (Check only one) 12 Certifying Physicien: To the 2 Medical Examiner: On the ba and mann	is of examination and/	death occurred at the tim or investigation, in my op	e, date and place, and du- inion, death occurred at th	e to the cause(s) ne time, date and	and manner as stated. It place, and due to the cause(s)				
M	29b. Signature and title of certifier	Managery .	29c. License	number 2 3 3 3		te signed (Month, Day, Year)				
	30. Name and address of person who completed cause Khalid Waseem, M.D.	, 1126 Opal	ype, Print)		21740					
ate trar	31. Date filed (Month, Day, Year) 32. Re DEC 3 0 2005	gistrat's Signature	to Specie							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 1

				State of Ma							•			C.	OOEL
		•	For State Registrar	Otato o. m.	ar y tarro		rtificate					Reg. No.	UU) 4,	3854
			1. Decedent's Name (First, Middle,	Last)							2. Date of Dea Month		, v	3. T	Time of Death
-	Physici /Medic		RONALS	TABB			,				12.31			6	-34AM
	Examin	er	4a. Facility Name (If not institution,		-41				Location o				County of		25
				OVE HOSPI		st birthday)	100		US VIC		8. Date of Birtl		-	TIMO	
	Funeral Director		212-13-0282	1⊠M 2□F		73 Yrs.	Months	Days	Hours	Min.	OCT • 2	r. Year)	932	Country) Washii	State or Foreign
	D.		Usual Residence of Decedent										,,,,		
	arylar show	5	10a. State 10b. County			Town or Lo									side City Limits
	the M	Director	Maryland Baltin	nore		Catons	ville					10a Citi	zen of Wha	at Country?	
	3a or		55 Wade Ave						228		1	-			f America
	death	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	13.	Was Deced			gin? (Spe	ecify Yes or No- Rican, etc.)		14. Race -	American Inc	
36	or ite	y Fu	1 X Never Married 2 Marrie	ld 1 ☐ Yes 2 🕅 I If Yes, Give	No		1 ☐ Yes			, 1 40110	inoari, oto.,		Specify:	White	۵
Ö	be filed within 72 hours after death with the Maryland tal Hygiene. of other than "natural", or items 23a or 28a-f show event, the Medical Evarili or mast by multipol at	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent*	Year or Dates:	1		dent's Usua					16h Ki		ess/industry	
15	in 72 n "nat	Completed	(Specify only highest	grade completed)		(Give	kind of wor DD NDT us	rk done d se retired	during most f)	of worki	ng	TOD. KI	ild of Busin	iess/ilidus(iy	
212	d within giene. ar than "	mo	Elementary/Secondary (0-12)	College (1-4or 5	0+)	None	2					No	ne		
pu	be filed tal Hygi d other event, L	a)	17. Father's Name (First, Middle, L	•					18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)		
yla	ould had	2	Samuel L. Tab	Total Manager			7-1				napiro			MD 200	206
Maryland 21215-0036	d 2 sh th and 7 is m treum						-								,
ē,	Heali Heali tem 2		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Nan	ne of						y or Town, S	
mol	ages ent of nt: If i							•		01.	/01/06	01n	ev. M	arylar	nd
Baltimore,	mit. partm portar y inju	19a. Informant's Name/Relationship (Type, Print) Dr. Marvin Tabb - Brother 20a. Method of Disposition 1 Georgia 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line.													
m	99		JAMA	<u></u>		10	191 Rc	ckvi	11a.I	Pika	Rocky	i11_0			
П			23a. Part 1. Enter the disease, or of shock, or heart failure. List of	complications that caused only one cause on each li	the death. ne.	Do not ent	ter the mod	e of dyin	g, such as	cardiac o	r respiratory ar	rest,	, 125	Appr	roximate val Between et and Death
	Prysician	r i	Immediate Cause (Final disease or condition resulting in death)	- ACUTE	CA	RAIDL	105CL	ILA	RA	RPE	ST			Onse	et and Death
	/Medical Examiner		resulting in deathy	Due to (or as			100	= 0	UEL	. 1.0	11. 1				
	Mag.	e	Sequentially list conditions, if any, leading to immediate	b. RIGHT Due to (or as	a conseque		LOB!	E 7	NEU	(190	NIA			-	
	sicien and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ACUTE	E	XACE	ERB/	4T1	OU	OF	COPD				
o,	be executed icien and burial-transit	Exa	resulting in death) Last	Due to (or as		ence of):	. /								
8760,	3 × 9	lical		(BEKY	akt	1710									
89 X	The law requires that the death certificat tite has been signed by the attending phy agge 2 should be detached for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnan	icv							12d Data a	f dollarons	
Вох	atten atten	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3[Ectopic pr Other (sp					1	23d. Date o Month	Day	Year
O.	at the de by the a tached	hysi	9 Unknown	9□ Unknown											
s, P	es tha igned be det	by P	Part II. Other significant condition		_	-		_							use of death?
ord	w require been si			IAGEAL							1 🗆 Y	es 2[□ No 3[Probably	4 Unknown
Records,	e faw r has be ge 2 sh	Completed	INTERMITTE	NT CHRON	10	REN	AL F	-AL	LURE	=	24a. Was autop	SV	prio	r to completi	ndings available on of cause of
al H											1 ☐ Yes	med? 2 No	dea 1 🗆	Yes 2021	No
Vital	Physicien: 1 this certifical ral director, p	o Be	25. Was case referred to medical examiner? 1 ❤ Yes 2 □ No	Hospital:	2 7 5	R/Outpatier	* 2000	Othe			(C <i>heck only o</i> ne 5 ☐ Resid			(2	
of			27. Mann of Death	28a. Date of Inju	ry :	28b. Time o		8c. Injury	/ at		ne 5∟ Hesid 28d. Describe h			<i>Зреспу)</i>	
ion	ath. rr: After	atio	1 Vestural 5 Pending 2 Accident investig	ation	y rear)	Injury	М	Work	Yes 2 🗆 1	No					
Division	tal or Attendii s after death. si Director: A ed in by the fu	Certification:	3 Suicide 6 Could not determine		ury - At hon c. (Specify)	ne, farm, str	reet, factory	r, office		2	28f. Location (S City or Tow			or Rural Rou	te Number,
	Hospital or Attending 24 hours after death. Funerel Director: Afte tely filled in by the fune														
	To the Hospital or within 24 hours afte To the Funerel Dir completely filled in	edical	29a. Certifier 1 ✓ Certifying (C second) 2 ☐ Medical E	Physician: To the best xaminer: On the basis o and manner st	f examination	rledge, deat on and/or in	h occurred vestigation,	at the tim , in my or	ne, date and pinion, deat	d place, a th occurre	and due to the o ed at the time, o	ause(s) late and	and manne place, and	er as stated. I due to the c	ause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier				290	. License	e number			29d. Dat	e signed (A	Month, Day, Y	Year)
	7/		Mm (Av	iton Win,	24510	in, h	(.0)	X	510	46		-	2-2		
	V		30. Name and address of person v			-	Print)	01.1	l Co-		own Rd,	C !			ida, MD
			A NTON F 31. Date filed (Month, Day, Year)	+. MINA	551	4 N	1904	010	Geor	geto	wn Kd,	Sul	Le /C	, 4	20814
	Sta Registi			32. Posistr 2 2006	ars Signati	G A	park	9							
	3			1											

			1 - For State Registrar			d / Dep		t of H	ealth and I	Mental Hygi		05		
	Dhysisi	010	1. Decedent's Name (First, Middle, La							2. Date of Death		Yea	3. Time of Death	
	Physici /Medio		Devon La'Verne Wilson Dece							December	18,	2005	5 18:58 PM	
	Examir		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea											
			Washington Adventist Hospital Takora Park							Montgomery				
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Under 1 Year 1 (Month, Day, Year) 38 Yrs. Usual Residence of Decedent							Wa	9. Birthplace (State or Foreign Country) Washington, DC			
0036	yland		10a. State 10b. County			y, Town or L							10d. Inside City Limits	
	e Ma	ctor	D.C. Washington								1 □X/es 2 □ No			
	th with th 23a or 26 ast be no	Funeral Director	1241 Howison Place, S.E									n of What	Country?	
	n 72 hours after death with the Marylan "natural", or Itams 23a or 28a-f show effect Exercities must be notified at		11. Marital Status 1 □XNever Married 2 □ Married	Armed Forces?	1 ☐ Yes 2 ဩNo				pecify Yes or No- Rican, etc.) 14. Race - American India Black, White, etc. Specify: Black			hite, etc.		
3	ural',	Completed by	3 Widowed 4 Divorced	Year or Dates:	Year or Dates:			1 ☐ Yes 2 ☑ No Specify:						
0500-C1212	be filed within 72 hc tal Hygiene. d other then "natur evant, Ire Medical	iete	15. Decedent's E (Specify only highest gr	ducation ade completed)	on 16a. Dece mpleted) (Give			al Occupa ork done d se retired	king 1	6b. Kind	ss/Industry			
V	filed within 72 Hygiene, hther thsn "nat ant, it e Medic	E G	Elementary/Secondary (0-12)	College (1-4or 5	Ollege (1-40r 5+)			Enfo	D.C. Gov			zornmont		
	filed withi Hygiene, other than ant, tre M	ပိ	17. Father's Name (First, Middle, Last)	Fal			التناث	ne (First, Middle, Maiden Sumame)			/elimeir		
<u>a</u>	should be nd Mental nmarkad c	To Be	Odell Philson						Barba	arbara Wilson				
Maryland	and M is mar	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir			ng Address (Street and Number or Rura			City or 7	Town, State, Zip Code)		
	カイトラ		Barbara W. Wade	- Mother		1241	Howi	son I	Place, S	V; Washin	gton	, D.C	20024	
e.	of Healt of Healt litam 2 r other		20a. Method of Disposition	Domestal from State	20b. P	lace of Disp emetery, cre	osition (Na	me of other place	9)	Date 2	oc. Loca	tion - City	or Town, State	
Ĕ	Pages ment of ant: If its ury or o		1 🎇 Burial 2 □ Cremation 3 □ 1 1 □ Donation 5 □ Other (Speci			lar Hi	ll Ce	meter	ry 01/0				Maryland	
baltimore,	permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service Lice	Flema	n					eman Funera J. Maryland				
	T .		23a. Part1. Enter the disease, or conshock, or heart failure. List only	pitations that caused one cause on each lin	the deat	n. Do not en	ter the mod	de of dying	, such as cardiac	or respiratory arres	it,		Approximate Interval Between	
1	Physician		Immediate Cause (Final disease or condition										Onset and Death	
	/Medical		resulting in death) a. Due to (or a -a consequence of):											
	Examiner		Sequentially list conditions	b										
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Libeas of injury	Due to (or as	Due to (or as a consequence of):									
5	ate be executed nysician and he burial-transit	Examiner	that initiated events resulting in death) Last	c										
68/60,	ficate be physicials the bu		d											
XOD	death certifical e ettending phy d for use as th	In/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy								230	23d. Date of delivery		
	0 0 0	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	4 Pregnant at time of death 5 □ Other (specify)								Month	Day Year	
<u>.</u>	as the	by										co use contribute to the cause of death?		
ecoras,	w require been slig should b	etec												
י ד	The la ate has page 2	Completed								24a. Was an autopsy perform 1 Yes 2	ed?	prior t death 1 \(\) Y		
Vila	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				26. Place of Death (Check only						
0	Phys this	To :	1 Yes 2 No 27. Manner of Death						e how injury occurred					
	ding h. After funer	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) Injury					28c. Injury at Work? M 1 ☐ Yes 2 ☐ No			28d. Describe how injury occurred			
DIVISION	or Attending after death, Director: After in by the fune	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Nur City or Town, State)			Rural Route Number,	
<u> </u>	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edicai C	29a. Certifier 1 Certifying Pl (Check only 2 Medical Exa- one)	nysician: To the best of miner: On the basis of and manner sta	examina	wledge, deal	th occurred	at the tim	e, date and place inion, death occu	and due to the cau	se(s) ar e and pl	nd manner ace, and d	as stated. lue to the cause(s)	
	To the within 2 To the comple	Mec							29c. License number 29d.			d. Date signed (Month, Day, Year)		
	F ≥ F 8										Z-19-7005			
0	_		30. Name and address of person who	completed cause of d	eath (Item	23a) (Type	Print	/ 0			16		2001	
_	. 3		Stephen Smith, M.D.	7600 Carroll				ntr Min	reland or	012				
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	ar's Signa	ture	uia Fd	LA, I'D	ryudii 2	714				
	Registr		JAN 1 0 2006	Marie	18	4	1							

			1 - For Stata Registrar		Maryland / De	partment ertificate				Rag. N	000	5	4385	6
	Physic	ian	Decedent's Name (First, Middle,	•					2. Date of D Month	Da	ay	Year	3. Time of D	eath
	/Medi		Frances	Р.	Waxman						30 20		2215	М
100	Examir	ner	4a. Facility Name (If not institution,		-			Location of D	eath	1	4c. County of Death Anne Arunde1 9. Birthplace (State or Country)			
			Anne Arundel M				apol:		Usa Taran					
*	Funeral		5. Social Security Number 092–16–7627	i.Sex 7 1 ☐ M 2 🛱 F	. Age (In yrs, last birtho	Months	Days	Hours N	Ain. (Month, D	ay, Year			place (State or Foreign ntry)_	
	Director		Usual Residence of Decedent	Λ.	84 Yrs				Mar. 2	20,	1921	New	York	
	land w	}	10a. State 10b. County		10c. City, Town o	Location						1	Od. Inside City	Limits
	Mary -teh	ō	MD Anne A	runde1	Annapo	n1is							1 ☐ Yes 2	XXo
	hours after death with the Maryland tursi', or Items 23s or 28s-f show at Examiner must be notified at	Je C	10e. Street and Number 10f. Zip Code							10a. C	itizen of W	hat Cour	ntry?	
		0	416 Monterey Avenue 21401								USA		,	
		era	11. Marital Status		lent Ever in U.S.					10-	14. Race - American Indian.			
Maryland 21215-0036	urs after deal ai', or itema	by Funeral Director	1 ☐ Never Married ② Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give	1 □ Yes 2 X No		Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e 1 □ Yes 2茲 No <i>Specify:</i>						etc. hite	
9	72 hours "natural", dical Exe	Completed	15. Decedent's		16a. De	cedent's Usual	Occupat	tion		16b. i	Kind of Bu	siness/In	ness/Industry	
21		pie	(Specify only highest Elementary/Secondary (0-12)	College (1-	4or 5+)	ive kind of worl e. DO NOT usi	k aone au e retired)	iring most or	working					
7	70 70 -	5	12			nemaker				(Own H	ome		
g	be filed stal Hygid of other event,	Be (17. Father's Name (First, Middle, La	ist)				18. Mother's	Name (First, Middle	e, Maide	n Sumame	9)		
<u>a</u>		ပ္	Robert Gertsch					Franc	es Lehmar	nn				
an	and em		19a. Informant's Name/Relationship						Rural Route Numi					
	s 1 and 2 f Health (tem 27 i		Susan Redos (Da	ughter)	58	8 Stev	ens :	Forest	Rd., #21	L, Co	olumb	ia,	MD 2104	5
ore.		1	20a. Method of Disposition 1 ☐ Burial 2XX remation 3		20b. Place of Di cemetery,	sposition (Namerematory or oti	e of her place,)	Date	20c. t	ocation - (City or To	own, State	
Ĕ	Pages nent of I	1	4 Donation 5 Other (Spe		Metro (Cremato:	ry	1-	7-2006	Bal	ltimo	re,	MD	
Baltimore,	permit. Page Department of Important: if eny injury or once.	1	21. Signature of Euneral Service Lie	ensee MI	1		esty	Funer	al Home, nue, Anna			D 21	401	
-			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that ca	used the death. Do not						20, 11		Approximate Interval 8etwe	00
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	_ a	r as a consequence of):								Onset and Dea	
	i je	iner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury)										-	
	cate be executed physician and the burial-transit	cam	that initiated events resulting in death) Last Due to (or as a consequence of):								<u>.</u>			
8760,	oe ex	Ē												
87	hysic the L	dicai		d	. d									
9	entifica ling pt e as t	Med	IF FEMALE:						4.40					
P.O. Box	at the death certificate be executed by the attending physician and teched for use as the burial-transif	Physician/M	23b. Was decedent pregnant in the past 12 months? 1							23d. Date of delivery Month Day Ye				1r
Records, P	es tha	þ	Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I.							use contribute to the cause of death?				
ö	w requir been sl should	mpieted							04- 146		045 14			
Re	0 5 0	ם			·				- 24a. Was		_ pi	rior to cor eath?	psy findings ava mpletion of caus	se of
_	ician: Th certificete ector, pag	S	25.11	-					1 ☐ Yes			□Yes	2 No	
Vital	sician: certific irector.	Be	25. Was case referred to medical examiner?	Hospital					Death Check only					_
ō	Phys ral di	.To	1 Yes 2 No 27. Mann eath	28a. Date of	oatient 2 ☐ ER/Outpa Injury 28b. Tim			4 🗀 Nursir	g Home 5 Res				y)	
E C	Attending Physician: r death. sctor: After this certific by the funeral director.	ion	1 ☐Natural 5 ☐ Pending	(Month	Day Year) Inju	y M	Work?	es 2 □ No	28d. Describe	now mil	iry occurre	ea .		
<u>S</u>	death death ctor: / the	ical	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no	t be 390 Glaco o	f Injuny - At home, form			95 Z NO	29f Location	/Stmat a	nd Numbo	5 05 Puse	1 Davida Museba	
Division	after Direct In by	Certification:	28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)								et and Number or Rural Route Number, State)			
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying (Check only 2 Medical Ex	caminer: On the bas	est of my knowledge, diss of examination and/o	eath occurred a investigation,	it the time	e, date and pl	ace, and due to the	cause(s	s) and mar	ner as s	tated.	
	To the within 2 To the complet	Mec	29b. Signature and ittle of certifier	and manner stated.						29d Da	ate signed	(Month	Dey, Year)	
)	F 3 F 8		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wicked Stzur 2ine 2201 Med Parkway Annables MD 214											
			30. Name and address of person wh			1.1	1 -	\geq i.	1		0	. 1.1	Do.	4
37			31. Date filed (Month, Day, Year)	W 21 m	istrar's Signature	1 100	c 1	acki	ray 71	nno	eper!	, (V)	12/2	01
	Sta Registi		JAN 0 9	2006	gistrar s Signature	1 0			1					
DHI	MH 17 Rev 1/2	140	3	2000	TOTAL SET	The same of the sa	/							

				1- State of Maryland / Department of Health and M Registrar Amend Item 29d per Dr., G851, 01/27/06dhb	fental Hygier Reg.	2005	43857				
		Physic		Decedent's Name (First, Middle, Last) John Cromwell	2. Date of Death Month December	³ 1. 2ŏ85	3. Time of Death 8:10P M				
	1	/Medi Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Deat	1				
	4			Manor Care Rossville Rosedale		Balt	imore				
		Funeral Director		5. Social Security Number 146-14-1257 6. Sex 7. Age (In yrs. last birthday) 15 Under 1 Year 15 Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Oct 19, 1	9. Birtl	nplace (State or Foreign untry) V Jersey				
5		and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits				
2/3/105 819N	1_	rs atter death with the Maryland I, or Items 23a or 28a-f ehow Kanilner , utet be notified at	tor	Maryland N/A Baltimore			1 XYes 2 No				
0)	or 28a	lrec	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Co	untry?				
3)	23a c	alD	306 South Highland Avenue 21224		USA					
7	_	Items	unei	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Spin Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White					
5)36	within 72 hours after ene." then "natural", or Ite ne Madical Exemina	Completed by Funeral Director	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No 1944 1 Yes, Give 1 966 1 □ Yes 2 □ Xivo Specify: Year or Dates: 1966		Specify: W	nite				
7	9	2 hou	ted	15. Decedent's Education 16a. Decedent's Usual Occupation	16b	. Kind of Business/l	ndustry				
	218	ithin 7	nple	(Specify only highest grade completed) (Give kind of work done during most of work) Elementary/Secondary (0-12) College (1-4or 5+)		M . 3 T	1 .				
T	12	TI 60 5		9 Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name		Metal Ind	lustry				
\exists	and	a d la	Be		e (First, Middle, Maid Ferenchia	,					
\geq	Maryl	d 2 should by th and Menta th and Menta ? Is marked traumatic so	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura			in Code)				
\$	Ma	12 ha		Karen Grasso, Daughter 1206 Old Mountain Road		-					
9	Je,	- I = =		20a. Method of Disposition 20b. Place of Disposition (Name of cametage or ametage	Location - City or						
£	E I	Pag nent int: I)2/06 Ba	ltimore,	Maryland				
H3	Baltimor	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Ligensee Thomas Gregor 22. Name and Address of Facility Cremation Society 299 Frederick Road	Of Maryla l Baltimor	nd Inc.	and 21228				
		Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line. Immediate Cause (Final			Approximate Interval Between Onset and Death				
		/Medical		resulting in death) Due to (or as a consequence of):							
	10	Examiner	L	Sequentially list conditions, b. Bularkal Censor variables	Disease						
		ed isit	Examiner	fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
		xecul and al-trar	хап	that initiated events resulting in death) Last Due to (or as a consequence of):							
	8760,	cate be executed physicien and the burial-transit	dical	6. Status port myoundal	mfaret	m					
39	9	entific ding p	/Med	IF FEMALE:							
3	O. Box	Attending Physiclen: The law requires that the death certificate the death. •ctor: After this certificate has been signed by the attending py the funeral director, page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1		23d. Date of deli Month	very Day Year				
	, P.O		y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to	to the cause of death? Probably 4 Minknown				
	Vital Records,			Diabetes	1 □ Yes	2□No 3□Pro					
	ဝ၁	e law re has bee	Completed	Hypercholetram	24a. Was an autopsy	24b. Were au	opsy findings available ompletion of cause of				
101	Ä	The lay	Som		performed	2 death?					
10.	/ita	ysiclen: Th is certificate director, pag	Be (examiner/	(Check only one)						
/	of o	to the Hospitel or Attending Physical thin 24 hours after death. To the Funerel Director: After this completely filled in by the funeral directors.	ို	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
gas	ion		atlon	27. Manney of Death 28a. Date of Injury 1 Actident 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 4 Describe how injury occurred 4 North, Day Year) 4 Describe how injury occurred 4 North, Day Year) 4 Describe how injury occurred 4 North, Day Year) 4 Describe how injury occurred 4 North, Day Year)							
E	Division		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
		e Hospita 124 hours Funere letely fille	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and place are considered and place and place are considered and place are considered.	and due to the cause ed at the time, date a	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)					
		within T th	₩	29b. Signature and title of certifier 29c. License number	29d. I	Date signed (Month	, Day, Year)				
	6	141		D 31464		nuary 2,					
_	1	H		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHOAIL A. HASHMI MD. 821 N. BUTAWST 6mts	308 Bal	home r	ND 21201				
	J.	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature							

DANIEL HAZZARD 05-08152 RKD

Unpend item#2xa,27,722 f,perin;ties-Black/dedelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician JOSHUA** DECEMBER 3, 2005 7:57A. DANIEL HAZZARD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHESTER RIVER HOSPITAL CHESTERTOWN KENT 5. Social Security Number **Unic** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
DEC. 2, 2005 **Funeral** Birthplace (State or Foreign Country) Months 1**X** M 2□ F Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show dical Examiner must be natified at KENT MD MILLINGTON 1 ☐ Yes 2X No by Funeral Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21651 USA 29723 MORGNAC ROAD death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No WHITE 3 Widowed 4 Divorced "naturel" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Mex Elementary/Secondary (0-12) College (1-4or 5+) infant infant other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H isnt: If Item 27 is marked of Be GEORGE EVANS HAZZARD PHYLLIS JEAN KACHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29723 MORGNAC ROAD, MILLINGTON, MD 21651 GEORGE E. HAZZARD/ FATHER 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Depertment of Importent: If eny Injury or once. CHESAPEAKE CREMATION 12-13-2005 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) CENTER 21. Signature of Fuperal Service Licens FELLOWS, HELFENBÉIN & NEWNAM FUNERAL HOME, P.A. 130 SPEER ROAD, CHESTERTOWN, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sudden Unexplained Death in Infancy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Attending Physicien: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) Box 68760 Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 1 XYes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Nnpatient 2 ER/Outpatient 31

28a. Date of Injury (Month, Day Year)

28b. Time of Injury Injury 7.05 A M Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 ☐ No 3 DOA To the Funeral Director: After th completely tilled in by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Unk 1 | Natural 5 Pending death. investigation 1 Yes 2 No 12/3/2005 7:05 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number of Rural Route Number, City or Town, State) 100 Brown St. 4 Homicide hours atter Hospital Chestertown, MD within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) DECEMBER 4,2005 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 PENN STREET BALTIMORE MARYLAND 21201 31. Date filed (Month, Day, Year) 32. Registra State **JAN 19** 2006 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND TIEM#8, perFH, G858, 8716706, WS

State of Maryland / Department of Health and Mental Hygiene. Amended # 23aptl per Phy, 1/18, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Přiysician Month Dev Year CARL WESLEY FLOYD December 28, 2005 7:25 A.M /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE BALTIMORE CITY If Under 1 Year | If Under 24 Hrs 5. Social Security Number 8. Date of Birth (Month, Day)(Pear) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours tXXM 2□ F Director 240-76-9275 57 1948 Whiteville, N.C. Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumetic event, the Madical Experient must be notified at tokYes 2 ☐ No Funeral Director Maryland Prince George's New Carrollton 10e Street end Numbe 10f. Zip Code 10g. Citizen of What Country? 20784 USA 8331 Verona Drive 12. Was Decedent Ever in U,S. Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 TNo Specify: Specify 2 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Federal Police Officer 12th +01 Federal Government 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell Floyd Mildred Faulk 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Josette L. Floyd/wife 8331 Verona Drive New Carrollton, Maryland 20784 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stete ö 4 ☐ Donation 5 ☐ Other (Specify) Injury Maryland Veterans Cem. 1/10/06 Cheltenham, Maryland 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility
Frazier's Funeral Home, Inc. MO 1453 389 Rhode Island Ave., N.W. Wash.,DC 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one reduce on each line. Approximate Interval Between Onset and Death **Physician** Pulmonary embolism Immediate Ceuse (Final diseese or condition resulting in deeth) /Medical a CARDIO-PULMONARY ARREST Examiner Due to (or as a consequence of) Examiner bunel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No δ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en autopsy performed? Be Completed 1 Yes 1 ☐ Yes 2 No 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 I Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. edicai 29a. Certifier

The lew requires that the death certificate be executed ettending physicien for use es the buriel Division of Vital Records, P.O. Box 68760. á ete hes been signe pege 2 should be After this certificate has or Attending To the within 2

e filed within 72 hours efter death with the Maryland al Hygiene.
other than "naturel", or items 23s or 28s-1 show

permit. Peges 1 and 2 should be f Depertment of Health end Mental I Important: If Item 27 is marked of

3altimore, Maryland 21215-0036

State Registrar

32. Registrer's Signature 31. Dete filed (Month, Dey, Year) **JAN 18** And 2006

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print)

29b. Signeture and title of certifier

Jouis Chang

min

29c. License number

State

ABJUCEAH

2006

31. Date filed (Month, Day, Year)

Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Itestiste 25 Mary lazes a Department Hest than O Mean of Oboline Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October **Physician** $1^{\frac{5}{7}}$, 2005 2100 Lawrence Calvin Miller /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery Suburban Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Oct 10, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ ¥M 2 ☐ F 78 255-30-7268 Yrs 1927 Camilia Ga Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other treumstic event, the Medical Examinar must be notified at Completed by Funeral Director 1 TYes 2 No Prince George's Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20613 United States 12718 Brandywine Rd filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 🏞 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Public Service Worker Government permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Importent: If item 27 is marked othe eny injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Arthur Calvin Miller Joyce Simmons ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosetta Miller/Wife 12718 Brandywine Rd Brandywine MD 20613 20b. Place of Disposition (Name of cometery, crematory or other pla Lincoln Cemetery 20a. Method of Disposition 20c. Location · City or Town, State other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10-21-2005 Suitland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Pope Funeral Home 2617 Penn Ave SE Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SUBDURAL HEMATOMA Day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the first and anying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner PPROVED BY MEDICAL EXAMINER The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): CERTIFICATION P.O. Box 68760, Physician/Medicai nse IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by Urinary Tract Infection 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Coronary Artery Disease 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Coagulopathy certificate 1 Yes 2**X**No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes SETTINO Medicai Certification: To 28a. Date of Injury To (Mogth, Day Year) 28b. Time of Injury 10/16/2005 Unknown 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred ⊈∑≨iataral 5 Pending Probable fall after death. Director: A 1 ☐ Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, Large 1901 Georgia Ave., Wheaton, III) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **nursing home** filled in by 4 Homicide 24 hours a 29a Certher 1 🗡 Certifying Physicians To the best of my knowledge, death becamed at the time, date and place, and due to the cause(s) and mainles as stated. within 24 ha To the Fundamental Completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifig 29c. License number 29d. Date signed (Month, Day, Year) 10-19-05 D0060117 MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Eric D. Park, M.I 31. Date filed (Month, Day, Year) AN 2 2006

M.D

and

32. Registrar's Signature

9901 Medical Center Drive, Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25, 27, 28a-f per ME, C852, 02,01,06dhb

Reg, No. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Year PM Jorsey 1:00 ctober /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HORKINS BAJVIEW Care Center Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yo 2/5/1960 Birthplace (State or Foreign Country) **Funeral** Days Year 1**∑** M 2□ F 45 218-76-1020 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Exercitive Learning Learnithed at 1 ☐ Yes 2 ☑ No Director MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or itams 23a or 1711 Woodhome Drive 21015 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3. ☐ Widowed 4 ☐ Divorced "naturai" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: if Itam 27 is marked other than any injury or other traumatic avent Elementary/Secondary (0-12) College (1-4or 5+) Welder Welding 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Dorsey Barbara McMillan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Amy Dorsey/Daughter 1711 Woodhome Drive Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Gardens of Faith 4 ☐ Donation 5 ☐ Other (Specify) 10/31/05 Baltimore, Maryland 22 Name and Address of Facility Miller-Dippel Funeral Home Inc. 21. Signature of Euneral Service Licensee 6415 Belair Road Baltimore, Maryland 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ventilator associated preumonia disease or condition resulting in death) /Medical **Examiner** respirator CENTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of use as the burial-transit uadriplegia Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? tressure Malnutrition 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 ☐ Yes 25 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X es 2XNo 1 Inpatient 2 EP/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? T Zavatural Injury Driver in auto/fixed object
Impact
28f. Location (Street and Number or Rural Route Number,
City or Town, State) 5 Pending 1 ☐ Yes 2XNo within 24 hours after death. To the Funaral Director: A 2 **a.** M 2 Accident investigation 07/01/1989 6 Could not be determined Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide roadway Rt 7, Rosedale, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only onel tha 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D04382 completed cause of death (Item 23a) (Type, Print) Bay vino errele 30. Name and address of person 5505 HOPKINS Crap 20 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Department	artment of Health and Mei	ntal Hygiene 25/06dh Reg. No	05-43863
			Decedent's Name (First, Middle, Last)	2.	Date of Death Month Day	3. Time of Death
	Physici /Medic		BOHDAN	FEDASH A	JOUST 10	
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Raltimore Cit	40.	. County of Death
			The Johns Hopkins Hoppital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		Date of Birth	9. Birthplace (State or Foreign
	Funeral Director		152-24-3374	Months Days Hours Min.	Date of Birth (Month, Day, Year) ept 23, 19	28 Country) unk
	ס		Usual Residence of Decedent		•	
	arylar ahow	<u>_</u>	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits 1 ☑Yes 2 ☐ No
	he M.	Director	MD Ball 10e. Street and Number	timore	10a Cit	tizen of What Country? unk
	72 hours after death with the Maryland natural', or Items 23a or 28a-f ahow diest Everilier mutte notified at	ai Dir	603 S. Ann Street	21231	109. 01	and the state of t
	Items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Specif f Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc.
900	ours af	by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No Specify:		Specify: white
21215-0036	- 2 39	Completed	(Specify only highest grade completed) (Give life. I	lent's Usual Occupation kind of work done during most of working DO NOT use retired)	unk 166. K	(ind of Business/Industry unk
	2 should be filed within and Mental Hygiene. Is marked other than "aumatic event, ILE ME	Be	unk 17. Father's Name (First, Middle, Last)	unk 18. Mother's Name (F	irst, Middle, Maiden	Sumame) unk
Maryland	should be tind Mental I	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	ng Address (Street and Number or Rural R	Poute Number, City o	or Town, State, Zip Code)
	1 and 2 Health a tem 27 ls		Johns Hopkins Hospital 600 M	N. Wolfe Street Bal	timore, M	D 21287
nore	Pages 1 and nent of He ant: If item		1 Burial 2 ICremation 3 IHemoval from State	sition (Name of Date natory or other place)	20c. Lo	ocation - City or Town, State
Baltimore,	permit. Pages 1 am Department of Heal Important: If item 2 any injury or other once.		'4 □Donation 5 ♥Other (Specify) in state 21. Signatur of Funeral Service Licensee Ronald S. Wade Drestor St	Name and Address of Facility	655 W. Bai	ltimore Street
	40344		23a. Part1. Enter the disease, or complications that caused the death. Do not ent	altimore, MD 21201 er the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	al acquired pneu		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of): P	ancreatitis		
	_xummor	J.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	RES MEUMONIA	-11	5- <u>5</u> -44-
	nsit	mine	Cause. Enter Underlying Cause (Disease or injury	- ^ ^	14	2 1111111
ć	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):	CERTIFICATION APPROVED	BY MEDICAL EXAMIN	<u>ER</u>
68760,	ysicia ysicia	edical	d	CEPTIFICATION APPROVED		
_	ntifical ng ph as th		IS SERVALE.	CERTITION		
P.O. Box	Physician: The law requires that the death certific tris certificate has been signed by the attending plant director, page 2 should be detached for use as it all director.	Physician/M		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
	res that igned b be deta	by Pt	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
rds	w require: been sig		RECENT OCCIPITAL COREBROVASCULAR	ACCIDENT	1 🗌 Yes 2,	No 3 Probably 4 □Unknown
Records,	e law re has bee je 2 sho	Completed	ATRIAL FIBRILLATION		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
a	n: Th licate r, pag		NON Q. WAVE MYOCARDIAL INFARC		1 Yes 2 X No	
Vital	sicial certii irecto	o Be	25. Was case referred to medical examiner? 1 Tes 2 No Hospital: Inpatient 2 ER/Outpatient	26. Place of Death (C		C ClOthar (Caretti)
of	g Phy er this		27. Manner of Death 28a. Date of Injury 28b. Time of		d. Describe how inju	6 Other (Specify) rry occurred
ion	nding ath. r: Afte	atio	1 X Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	M 1 ☐ Yes 2 ☐ No		
Division	sfter des Directo	ertification:	3 Suicide 4 Homicide Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office 28f	. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)
_	To the Hospital or Attending Physician: The within 24 hours siter death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) Certifying Physician: To the basis of my knowledge, death (Check only one) Certifying Physician: To the basis of examination and/or invane) and manner stated.			
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number		ate signed (Month, Day, Year)
,			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		
			DAVID COSGROVE, JOHNS HOPKINS HOSPITAL, GO	DO NORTH WOLFE STREET, A	ACTIMORS ,	MARYLAND, 21287
	Sta Régist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	A#		
			IAN 2 7 2006	5 A		

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Department / Department / Departm	artment of Health and Mental Hygi	ene g. No. 05 - 43864
, A	Physici		1. Decedent's Name (First, Middle, Last) Nadia H. Mazor	2. Date of Death 1 1 - 2 6 - 3	
	/Medic Examin	ner	4a. Facility Name (If not institution, give street and number) 8806 Victory Avenue	4b. City, Town, or Location of Death Baltimore Parkville	4c. County of Death Baltimore
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 TF 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 0 8 - 0 5 -	9. Birthplace (State or Foreign Country) New York
	within 72 hours after death with the Maryland ene. than "natural", or itema 23s or 28s-1 show he Madical Exeminatment be notified at	Direc	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo MD. Baltimore Baltin 10e. Street and Number	more 104. Zip Code 10	10d. Inside City Limits 1 ☐ Yes 2 ☑ No 2g. Citizen of What Country?
9036	nours after dea ural', or Itema Exeminer m	d by Funeral	1 Never Married 2 Married 1 Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:	14. Race - American Indian, Black, Whita, etc. Specify: White
21215-0036	be filed within 72 ho ital Hygiene id other than "natur event, the Missical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give life.)	kind of work done during most of working DO NOT use retired)	6b. Kind of Business/Industry
Maryland	should be filed withir nd Mental Hygiene. I marked other than umatic event, IDB M	To Be	17. Father's Name (First, Middle, Last) Michael Horodowicz	18. Mother's Name (First, Middle, M	nanchile
Baltimore, Mai	es 1 and 2 and 2 of Health ar fitem 27 is r other trau		20a Method of Disposition 2 Departure 1 20b. Place of Disposition 1 Departure 2 Departure 2 Departure 1 2 Departure 2 Departure 1 2 Departure 2 Depart	matory or other place) AUSSIGN OUT A DEPOSTOR CON NOV. 29,2005	Home Maytry 21037, 20c. Location - City or Town, State
Balt	permit. Page Department Important: I eny injury o		21. Signature Muneral Service Lipenses 22	2. Name and Address of Facility Evens Chap 800 Harford Road, Park	pel of memories! Kuille Manyland 21234
*	Physician /Medical		23a. Part1. Enter the disease, of complications hat caused the beath. Do not ent shock, or heart failure List only ene cabse on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		Interval Between Onset and Death 1 week
3760,	ate be executed nysician and he burial-transit	Ical Examiner	Sequentially list conditions, 1 any leasn the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. encephalopathy Due to or as a consequence of: C.V.A. subdura: Due to (or as a consequence of): d.	1 hematoma	3 months 3 months
P.O. Box 68	The law requires that the death certificate be exate has been signed by the attending physician page 2 should be detached for use as the burial	Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
Records, P.	requires that een signed b nould be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the u Atrial Fibrillation, post, ster Atherosclerotic cardiovascuar disease	nt in coronary	accoluse contribute to the cause of death? s X No 3 Probably 4 Unknown
al Rec	The lay ate has page 2	e Completed	arteries (6 months ago), on asj	pirin & Plavix 24a. Was ar autopsy perform 1	prior to completion of cause of death? No. 1 Yes 2 No. n/a
Division of Vital	Attending Physician: r death. sctor: After this certifici by the funeral director.	To B	examiner? 1 XYes 27. Manner of Death Windtural 2 Pending investigation 28a. Date of Injury (Month, Day Year) 9/06/2005 Unknown	of 28c. Injury at Work? OWT 1 Yes 22 No Subject	nce 6 □Other (<i>Specify</i>) w injury occurred fell
Div	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Certification:	28e. Place of Injury - At home, farm, stream of the building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	e pour vici	eet and Number or Rural Route Number, State) Nee, Parkville, MD use(s) and manner as stated
	To the Hos within 24 h To the Fur completely	Medica	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated. 29b. Signature and title of certifies	nvestigation, in my opinion, death occurred at the time, da	ite and place, and due to the cause(s) Id. Date signed (Month, Day, Year)
			30. Name and address of page 1 mino completed cause of death (Item 23a) (Type,		11-28-2005
	St	ate	P.C. Kahle, M.D., 7505 Osler Dr 31. Date filed (Month, Day, Year) 2 7 2 16 gistras Signature	rive #305, Towson, MD.	21204
4	Regist		11-28-2005-		

			For State Registrar	State of Mar		ertificate of		and M		giene Reg. No. (25	-43865
	Physici		1. Decedent's Name (First, Middle, Las Vivian Koehler	(1)					2. Date of De Month Novembe	Day	2005	3. Time of Death 6:25 a
Y	/Medic Examin		4a. Facility Name (If not institution, give Genesis Loch F			4b. City, Town, o	r Location o	of Death			ounty of Deat	h
	Funeral Director		5. Social Security Number 6. S		In yrs. last birthda 88 Yrs.		If Under a	24 Hrs. Min.	8. Date of Bir MAR 11	th		hplace (State or Foreign untry) PA
	aryland	2	Usual Residence of Decedent 10a. State 10b. County MD Baltimo		Oc. City, Town or Tows							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ith the M	Director	10e. Street and Number	,16	10%3	10f. Zip Code 2123)/.				n of What Co	ountry?
36	i within 72 hours after death with the Maryland iene. r than "natural", or Items 23a or 28a-f ahow the Medical Ezaminer must be notified at	by Funeral	8729 Emge Road 11. Marital Status 1 🗷 Never Married 2 🗆 Married 3 🗆 Widowed 4 🗀 Divorced	12. Was Decedent Ev. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	er in U.S. 13	. Was Decedent of I If Yes, specify Cub	Hispanic Orig an, Mexican	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.))- 14.	Race - Ame Black, White	
Maryland 21215-0036	n 72 n na n na	Completed t	15. Decedent's E. (Specify only highest gra	ducation	(Giv	edent's Usual Occup re kind of work done DO NOT use retire	pation during most d)	t of worki	ing		of Business/	Industry
rland 2	be filed stal Hyg od othe avant,	To Be Co	17. Father's Name (First, Middle, Last, Warren Koe	hler			Anı	na	(First, Middle Pear1	, Maiden Su Sch	upp	
	d 2 sh h and 7 ia m traum		19a. Informant's Name/Relationship (Katherine Fain			iling Address (Street W. Bel Ai						Zip Code) 21001
nore,	Pages 1 and 2 nent of Health int: if Item 27 I		20a. Method of Disposition 1 Burial 2 Cremation 3	Memoval Irom State		position (Name of ematory or other pla ike Cremat			oate		tion - City or	
Baltimore,	permit. Page Department Important: If any injury o		4 Donation 5 Other (Specification of Funeral Service Licer		M00986				ohrmanr s Drive		tsvill son, M	
*	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause on each line. Pneumoni								Approximate Interval Between Onset and Death 3 Weeks
	/Medical Examiner			Stroke	consequence of):							2 months
760,	ate be executed hysicien and the burial-transit	ical Examiner	Sequentially list conditions, it any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):							
.O. Box 687	death certific e attending pi id for use as t	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir	Fetal death	B □Ectopic pregnanc B □ Other (specify) _	y			230	d. Date of del Month	ivery Day Year
Δ.	sign d be	þ	Part II. Other significant conditions of	contributing to death but	not resulting in the	underlying cause gr	ven in Part I.		1			o the cause of death?
al Records,		Completed							24a. Was auto perfe 1 \(\text{Yes}	psy ormed?	24b. Were at prior to death?	utopsy findings available completion of cause of
ion of Vital	Attending Physician: Thir death. actor, After this certificate by the funeral director, pag	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 X No 27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	2 ER/Outpat 28b. Time Year) Injun	of 28c. Inju	her: 4 🛛 Nu	ursing Ho	me 5 ☐ Res 28d. Describe	idence 6 [city)
Division	in Dir	Certification:	3 Suicide 6 Could not be determined		y - At home, tarm, (Specify)	street, factory, office				(Street and I wn, State)	Number or Ri	ural Route Number,
_	To the Hospitel or Attenwithin 24 hours after deat To the Funeral Directors completely filled in by the	Medical C		nysician: To the best of miner: On the basis of e and manner state	xamination and/or							
	To the within To the comp	M	29b. Signature and title of certifier	There is	ong	29c. Licen DO154	se number 414				signed (Mont lary 2,	h, Day, Year) , 2006
	1		Vuong Vu Nguyen				imore	, MD	21206			
	St Regist	ate rar	31. Date filed (Month, Day, Year) FEB 0 3 200	2. Registrar	s Signature	is si						

			1 - For Amend Items	23aterefilds	agystan		d852) rtificate			ald PN€		giene Reg. No.	NE	-4	3866
	Dhusisi		1. Decedent's Name (First, Middle, Last,							1	2. Date of De Month	ath Day	Year		ime of Death
	Physici: /Medic		VIRGINIA	GENEVIEVE	KII	LLEN							8TH, 2		16:15 [™]
	Examin	er	4a. Facility Name (If not institution, give	street and number)			4b. City, 7	Town, or i	Location of	f Death		4c.	County of Dea	ath	
			MEMORIAL HOSPITAL		- //	E A fo findle do 1	CUMB If Under		ND If Under 2	A Hrs.	0.4. 40:		LLEGHAN		A
	Funeral Director		5. Social Security Number 6. Security Number 1	M 2KDXF 7. Age	9 (<i>in yr</i> s. 9]	last birthday) Yrs.	Months	Days	Hours	Min.	3. Date of Bir (Month, Da 07/23/	n y, Year) 101/	9. BI	nnplace (i ou <i>ntry)</i> MFCRI	State or Foreign URG, PA
			213-50-6290 Usual Residence of Decedent				1				07/23/	1714	WAI	MEOD	JRG, IA
	laryland show		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation								side City Limits
	aa-1 s	Director	MD ALLEGHAN	1Y		(CUMBER	LAND)					1 12	⊒Yes 2 □ No XX
	ith th	Dire	10e. Street and Number				10f. Zip					-	zen of What C		
	s 23s	ral	753 FAYETTE STE				Was Bassad	215		-i=0 (C	itu Vaa aa Na		IERICA 14. Race - Am		
	ter de Item	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent 8 Armed Forces? 1 ☐ Yes 2 ☑ 1		.5. 15.	If Yes, speci	fy Cuban	, Mexican,	, Puerto R	ify Yes or No ican, etc.)		Black, Wh	ite, etc.	naii,
99	urs af	by F	3 Midowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	No No	Specify:				Specify: W	HITE	
2	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or ferms 23a or 28a-f show other then "natural", or ferms 23a or 28a-f show event, I'm Medical Exercit en rount be notified at	Completed	15. Decedent's Edu (Specify only highest grad			16a. Dece	dent's Usual	Occupat	tion	of working	7	16b. Ki	nd of Busines	s/Industry	
2	Aithin ne.	mpl	Elementary/Secondary (0-12)	College (1-4or 5	+)		kind of word					_	D.110		
2	iled w tygiei her ti	Co	17. Father's Name (First, Middle, Last)	4			reache	,	19 Mother	r's Name	First, Middle,		DUCATI	ON	
anc	d be find the of other of other of other o	Be	FREDERICK HEN	V DAIIITE					JESS]		YOUNG		Surname)		
Maryland 21215-0036	2 should be filed withir and Mental Hygiene. Is marked other then aumatic event, Ite Mi	2	19a. Informant's Name/Relationship (Ty			19b. Mailie	ng Address						r Town, State,	Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiens. Important: If item 27 is marked other then "natural", or items 23a or 28a-1 show any hojury or other traumatic event, If a Healton Exerting cast be ricilited at any hojury or other traumatic.		RONALD WHETSELL (CA	ARE GIVER))		-					-	RLAND,		
Je,	of Health of Health fitem 27 r other tr		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nam	e of	i	Da	-		cation - City o		***************************************
E	Pages nent of I ant: If its ary or o		1 ☐ Burial 2 🖺 Cremation 3 ☐ F `4X☐Donation 5 ☐ Other (Specify)			Ј МЕМОН			1	10/10	/2006	MORG	ANTOWN	, WV	
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licens	1			2. Name and				mp37				
ш	205 # 9		Robert J. Dol	yardco	09	101 P	/U HUM BOX	9131	, MOI	REGIS	TKY OWN, W	V 26	506	1 .	
			23a. Part 1. Enter the disease, or como shock, or heart failure. List only of	ne cause on each lir	the deat	h. Do not ent	er the mode	of dying	, such as c	cardiac or	respiratory a	rrest,		Interv	oximate val Between et and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	BOW	el	rer:	fora	tio	7			1		1-1-	Day-
	Examiner			Due to (or as	a conseq	uence of):			1	1	1/	MINER			·
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseq	uence of):			7.6	PROVEDE	Y MEDICAL EX	Children			
	ocuted nd transi	Examiner	Cause (Disease or injury that initiated events	3				CERTIF	CATION						
8760,	cate be executed physician and the burial-transit	EX	resulting in death) Last	Due to (or as	a conseq	uence of):									
	physic	dical		d											
9 X	certifi ding use as	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome	of pregna	ancy		_					23d. Date of de	elivery	
Вох	death a atter	Iclar	in the past 12 months?	1□Live birth 4□Pregnant at			□Ectopic pre □ Other (spe						Month	Day	Year
O.	it the by the tacher	Physician/Med	9 🗆 Unknown	9□ Unknown											
s, D	Attending Physician: The law requires that the death certificate be executed croseth. croseth. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions con Hypertensive Ather	ntributing to death bi	it not res	ulting in the u	nderlying ca	use giver	in Part I.	e			se contribute		
Records,	w requir been si should	Completed	i.					-			1 🗆 '	Yes 2l	⊴ No 3∐ F	robably	4 Unknown
ec	e taw has b	nple									24a. Was autor		24b. Were a prior to death?	completion	ndings available on of cause of
ᇤ	ysician: The is certificate hadirector, page										1 Yes	2 No	1 Ye		10
Ž	siciar certif recto	Be	25. Was case referred to medicat examiner? 1 Yes 2 No	lospital: 1 Inpatie		50/0		Other	-		Check only o				
o	g Phys	n: To	27. Manner of Death	28a. Date of Injur	v	ER/Outpatier 28b. Time o		Bc. Injury Work	4 1 1401		d. Describe		G □Other (Sp. y occurred	өспу)	
<u>io</u>	ath. r: Afte	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day	/ Year)	Injury	М		r es 2⊡N	10					
Division of Vital	or Attending later death. Director: After in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ury - At he	ome, farm, str	eet, factory,	office		28	f. Location (S City or Tox		d Number or F	Rural Rout	'e Number,
	ital or irs afte rel Dir led in l									1					No.
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one)	sician: To the best of ner: On the basis of and manner sta	examina	wledge, deat tion and/or in	h occurred a vestigation,	it the time in my opi	, date and nion, deatl	d place, ar h occurred	d due to the d at the time,	cause(s) date and	and manner a place, and du	is stated. le to the c	ause(s)
	To t To tl	M	29b. Signature and title of certifier	P			29c.	License	number			29d. Dat	e signed (Mor		
1			•	M	mo]	03328	0		Uc	+ 19	200)
	3		30. Name and address of person who co	-					10:	~	DDT 1		0.150		
	Sta	te.	GUPTA, SUNIL K., 31. Date (filed to forth, Day, 7947)	M.D., 625	KEN Signa	T AVEN	UE, S	UITE	101,	CUM	BERLAN.	υ , Μ	D 21502	<u>-</u>	
	Registr		LED 0 7, 7000	A STATE OF THE STA	de de la										

DHMH 17 Rev 1/2001

9

		1 - For State Registrar	State of Marylar	-	artment rtificate			nd M	R	eg. No.	acc	5-4386
Physic /Med		1. Decedent's Name (First, Middle, Last Birtrous Delano	,						2. Date of Dea Month Decembe	Day	Year 2005	3. Time of Death 11:00 A ^M
Exami		4a. Facility Name (If not institution, give			-		Location of	Death		4c. C	ounty of De	
		10904 Piscataway 5. Social Security Number 6. Se		last birthday)	Cli1	nton 1 Year	II Under 24	4 Hrs.	8. Date of Birth	Pri		George's inthplace (State or Foreign
Funeral Director	2.5	230-88-9451	7. Age (In yrs.	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Sept. 3	, 195		rginia
land land		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation		·					10d. Inside City Limits
Many a-f sho	tor	Maryland Prince Ge	orge's C1	inton								1 ☐ Yes 2 🛛 No
or 28	Director	10e. Street and Number			10f. Zip				1	0g. Citize	n of What (Country?
sath w	erai	10904 Piscataway	Road 12. Was Decedent Ever in U	6 12	2073		nania Origin	in 2 / Cma	oitu Vaa as Na	U.S.		nerican Indian,
be tited within 72 hours after death with the Maryland tal Hygiene. Individual than "neturel", or items 23e or 28e-1 show event, the Medical Exeminar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:		I Yes, spec	ify Cubar	n, Mexican, I	Puerto P	cify Yes or No- Rican, etc.)		Black, Wh	
72 ho	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usua kind of wor	k doné di	uring most c	of workir	ng	16b. Kind	of Busines	s/Industry
Idel yidelid Z IZ IO-0000 2 should be filed within 72 hours aft and Mental Hygiene. I is marked other than "neturel", or raumatic event, tra Madical Examp	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)		<i>DO NOT u</i> s Oping					Q.V.	C.	
Hygi other	0	17. Father's Name (First, Middle, Last)			F 6			s Name	(First, Middle,			
nd 2 should be file the and Mental Hy 27 is marked oth traumatic event	To B	Robert Samuel Wa	tson				Edith					
c, man years and 2 should the ath and Mer traumatic other traumatic		19a. Informant's Name/Relationship (T)							Route Number			
Health Health tem 27		Fannie High (Si 20a. Method of Disposition	ster)	Place of Dispo cemetery, crer					linton,			r Town, State
Pages nent of I		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Terrioval Iloni State	rver Me				2/18	3/05	Suff	olk,	VA
permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or other tra		21. Sign ture Funeral Service Licens	Muneu	22	Name and Crocke	d Address er Fu Was	s of Facility ineral shingt	Horon s	ne, Inc	Efolk	. VA	23434
Physician /Medical Examiner physician and physician and the primin-fransit	ical Examiner	cause. Enter Underlying Cause (Disease or injury	a. Due to (or as a consect b. Due to (or as a consect c. Due to (or as a consect d.	uence of):	2		186	2 A				
the death certific by the attending p ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnance of Degree of Control	Il death 3	Ectopic pre					230	d. Date of de Month	alivery Day Year
ires that signed b	þ	Part II. Other significant conditions co	ntributing to death but not res て M M さい の									to the cause of death?
The law requires to the has been signed age 2 should be o	Completed		71,77,070,000	, , , , , ,		V			24a. Was a autops		prior to death?	
ysicien: The is certificate hi director, page	a	25. Was case referred to medical					26. Place o	of Death	(Check only on		1 □ Ye	s 2 No
Physiclen: Tribis certifical	ToB	1 Les 2 140		ER/Outpatien			4 🗆 Nurs	sing Hom	ne 5⊠Reside	ence 6	Other (Sp	ecify)
Jing P After t funera	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 28	Work			8d. Describe ho	w injury o	occurred	
l or Attending after death. Director: Afte	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · At h building, etc. (Specif	ome, larm, str (y)			es 2∐No	/	8f. Location (St City or Town		Number or F	Rural Route Number,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attercompletely filled in by the funeral	Medical Co	29a. Certifier 1 Gertifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knot ner: On the basis of examina and manner stated.	owledge, death	n occurred a vestigation,	at the time in my op	e, date and i	place, a	nd due to the cad at the time, d	ause(s) an	nd manner a ace, and du	as stated. ue to the cause(s)
To th within To th compl	Me	29b. Signature and title of certifier				License	I .		2	9d. Date s	signed (Mor	nth, Day, Year)
		3 mol V	~ Jobeny ~	9			986			12	-29	-2005
8		30. Name and address of person who ca	ompteted cause of death (Iter A W A Y A A 32. Registrar's Signa	m 23a) (Type,	Print)	701	1	M	5 2	073		
St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 1 7 2006	32. Registrar's Signa	ature	,			-				

05-8145 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Unpend item#2,2a,PII,27,pen#E,0852,2/9/05 TI State of Maryland / Department of Health and Mental Hygiene B.K.S CAROLYN M. RAFTARY 1 - State Registrer Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) . ^{Day} 2005 **Physician** DEC. 2, Raftary 2:20 p.m. Carolyn Millwood /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ST.MARY"S ST.MARY'S HOSPITAL LEONARDTOWN If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 22F Yrs. 49 April 25,1956 248-08-9968 Georgia Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. ?? Ie marked other than "nature!", or Items 23a or 28a-f ehow traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland St. Mary's Hollywood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 24967 Pinto Drive 20636 United States Completed by Funeral Pages 1 end 2 should be filed within 72 hours after death nent of Heelth and Mental Hygiene. ant: If Item 27 Ie marked other than *naturel', or Items 23. 12. Was Detedent Ever in U.S. Armed Forces? 1 ■Yes 2 □ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 E No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Richard Millwood Evelyn McDonald ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l other tra 24967 Pinto Drive, Hollywood, Maryland 20636 Vincent J. Raftary / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of H tmportant: If its eny injury or of once. 1 ☐ Burial 2
Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre. 12-6-2005 | Charlotte Hall, MD 21. Signature of Funeral Service Inconsee Edward N. Brinsfield, Jr. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Cardiac Arrhythmia as Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardial Fibrosis, Focal Bronchopneumonia and Small Infarct of Lung disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien end s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Fatty Liver 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of deat/?

1 ☑ Yes 2 ☐ No 24a. Was an 1 Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Minpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 □ No this After this funeral of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred 1 X Natural 5 Pending after death. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) i b within 24 hours after To the Funeral Direct 4 🗌 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4, 2005 O.C.M.E DEC. (MV) Williams

State Registrar 31. Date filed (Month, Day, Year)

33441

111 PENN STREET, BALTIMORE, MARYLAND 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 0 8 2006

KORFLU

32. Registrar's Signature

		-	For State Registrar	State of	f Maryland / Dep Ce	partment of F		Re	g. No. 200.	5-43870
	Physicia	an	1. Decedent's Name (First, Midd GENEVA LEE MOY					2. Date of Death Month	Day Ye 26, 200	3. Time of Death er 8:00 P M
	/Medic Examin		4a. Facility Name (If not institution		nber)	4b. City, Town, o	Location of De		4c. County of D	
			205 NEW TOWN I			CHESTER		tro la puri (Birt	QUEEN A	
Ī	Funeral Director		5. Social Security Number 006-56-3866	6. Sex 1 ☐ M 2 X F	7. Age (In yrs. last birthda) 52 Yrs.	Months Days	Hours M			Birthplace (State or Foreign Country) VA
	pu .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	ocation				10d. Inside City Limits
	Maryia fedel	ō		ANNE'S	CHESTER					1 ☐ Yes 2 📉 No
	or 28a	Director	10e. Street and Number	AMAL 5	CHESTER	10f, Zip Code		10	g. Citizen of What	t Country?
	ath wi	rai	205 NEW TOWN I			21619			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at Quee.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorce	ried Armed Fo 1 ☐ Yes If Yes, Giv	rces? 2 X No	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ▼ No	an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		American Indian, Vhite, etc. BI.ACK
21215-0036	72 hou natura	eted !	15. Decede	nt's Education est grade completed)	16a. Dec	edent's Usual Occup	ation during most of v	working 1	6b. Kind of Busine	ess/Industry
12	within and the man	Completed	Elementary/Secondary (0-12)	College (1	-4 or 5+)	DO NOT use retired ASTOR	a) 3		RELIGION	
0 0	filed v Hygie other i		12 17. Father's Name (First, Middle		CO-PA	ASTUK	18. Mother's N	Name (First, Middle, M		
Maryland	Mental Mental arked o	To Be	WILLIAM H. BRA	YBOY			JUANIT	TA ALCORN		
/an	2 sho		19a. Informant's Name/Relation					Rural Route Number,		te, Zip Code)
e,	1 and Health tern 27		REV. JESSIE MC 20a. Method of Disposition	JYER, SR./I	20b. Place of Dis	position (Name of		Date 2	21619 Oc. Location - City	or Town, State
E O	Pages ent of nt: If it		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (State	ematory or other place TT.I.E CEME!	1	/31/2005 S	STEVENSVI	LLE. MD
Baltimore,	permit. Depentminimports any inju		21. Signature of Funeral Service	Licensee	// .	22. Name and Addre	ss of Facility		M FUNERA	L HOME, P.A.
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that c t only one cause on e	aused the death. Do not e	nter the mode of dyir	ng, such as card	liac or respiratory arre		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	melaela	Cane	Cance	es .		
	Examiner			Due to	(or as a consequence of):	Cane	es			
	n ≈	ner	Sequentially list conditions, Tany leading to immediate cause. Enter Underlying	b. Due to	or as a consequence of					
	cate be executed oblysician and the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c.	(or as a consequence of):					
8760,	sician buria			d —	,					
9	tificate ng phy as the	Medic	IS ES MAIS							
.O. Box	ne death certificate be executed the attending physician and hed for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ☐ Live b	ant at time of death	B Ectopic pregnancy Control of Co	/		23d. Date of Month	delivery Day Year
Δ.	that the ed by detac		Part II. Other significant condit	ions contributing to de	eath but not resulting in the	underlying cause giv	en in Part I.	23e. Did tob	acco use contribu	te to the cause of death?
rds	·= 0 0	ed by						1 □ Ye	s 2 No 3	Probably 4 Unknown
Vital Records,	0 0	Completed				- April - Apri		24a. Was ar autopsy perform	prior deat	e autopsy findings available to completion of cause of h? Yes 2 \sum No
ital	sician: Th certificate rector, pag	Be C	25. Was case referred to medic examiner?	1				Death (Check only one	9)	
of \	S S	ဥ	1 ☐ Yes 2 ☑ No		Inpatient 2 ER/Outpat			g Home 5 Teside		Specify)
Ou	ding h. After fune	tlon	27. Manner of Death 1 Natural 5 Pend 2 Accident inves	ing (Mon	of Injury 28b. Time th, Day Year) Injury	/ Wo	yat rk? Yes 2 □ No	280. Describe no	w injury occurred	
Division	al or Attending s efter death. i Diractor: After d in by the fune	ertification;	3 Suicide 6 □ Could	not be 28e. Place	of Injury - At home, farm, ing, etc. (Specify)	street, factory, office		28f. Location (Str City or Town	eet and Number o , State)	or Rural Route Number,
	To the Hospital or Atte within 24 hours efter de To the Funeral Diracte completely filled in by ti	edical C		I Examiner: On the b	best of my knowledge, de asis of examination and/or ner stated.	investigation, in my	pinion, death o	ccurred at the time, da	ite and place, and	due to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certification	er //	. 1	29c. Licens	se number	29	d. Date signed (fonth, Day, Year)
•			Cur	w Ha	n-M)		5 330	5	17/2	8/03
			30. Name and address of perso	who completed caus	se of death (Item 23a) (Type	Sate Ro	15/	300 Ama	refes 20	11) 2/44
	St Regist	ate rar	31. Date filed (MEC 2 9	2005	e of death (Item 23a) (Type 900 BPS tegistrar's Signature	andi.				

			1 - For State Registrar	State of M	aryland	-	rtment of tificate of		nd Mental Hy	giene Rag. No.	2003	-43871
	Physicia	an	Decedent's Name (First, Middle WILMA N.	, Last) SPRAY				.,,	2. Date of De Month	Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town,	or Location of	DECEMB Death		ounty of Death	1:20 A ^M
			503 TEAL COU				CHEST		Allia I a a		EEN ANNI	
	Funeral Director		5. Social Security Number 500–24–5040	6. Sex 7. Ag	je (In yrs. las	st birthday) Yrs.	If Under 1 Yea Months Days		Min. 8. Date of Bi	2, 1927	9. Birthp Cour MISSO	
	land bw		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Los	cation				1	0d. Inside City Limits
	Marylan a-f show	tor	MD QUEEN	ANNE S	CHI	ESTER						1 ☐ Yes 2 XNo
	vith the	Director	10e. Street and Number	TOM:			10f. Zip Code			10g. Citize	an of What Cour	ntry?
	leath v ns 238	Funeral	503 TEAL COL	JKI. 12. Was Decedent	Ever in U.S.	13. V	216 Vas Decedent of	Hispanic Origi	in? (Specify Yes or No	o- 14	USA 4. Race - Americ	
36	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. It a Medical Examinational proces.	by Fun	1 Never Married 2 Marri 3 Widowed 4 Divorced	ed 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates:			Yes, specify Cu ☐ Yes 2X No		Puèrto Rican, etc.)	s	Black, White, Specify: WHI	
2-0	72 hou nature	eted	15. Decedent (Specify only highes			16a. Deced	ent's Usual Occi	ipation during most of	of working	16b. Kind	d of Business/Inc	dustry
21215-0036	within ane. than "	Completed	Elementary/Secondary (0-12)	College (1-4or		life. D	RACT AD	ed)	_	ELE	ECTRONIC	S
	illed Hygie other	Be Co	17. Father's Name (First, Middle, I	Last)				T	's Name (First, Middle	, Maiden S	итате)	
Maryland	ould be Menta arkad atic ev	To E	ERNEST JONES						IA ENGLE			
Mar	d 2 sh th and 7 ls m traum		19a. Informant's Name/Relationsh PATRICIA VEON	_					or Rural Route Numb	-		
	s 1 an of Heal item 2 othar		20a. Method of Disposition		20b. Pla	ce of Dispos	sition (Name of patory or other pl		Date	20c. Loca	ation - City or To	own, State
altimore,	Page ment o ant: If ury or		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (St			SAPEAK	E CREMA	CION	JAN 3,2006	DIL	EVENSVIL	
Balt	permit. Departi Import any inf		21. Signature of Suneral Service I	Licensee	<u> </u>	FE 10	LLOWS,	ess of Facility IELFENB	EIN & NEWN D CHESTER,	IAM FU	NERAL H	OME, P.A.
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications hat cause only one caused neach li	d the death. ine.	Do not ente	er the mode of dy	ing, such as ca	ardiac or respiratory a	rrest,	1015	Approximate Interval Between Onset and Death
	Fnysician /Medical	š li	Immediate Cause (Final disease or condition resulting in death)	_aEn	d 57	-	Renal	Dure	معو			3 45
	Examiner			Due to (or as	a conseque	ncel of):						/
	P is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as	a conseque	ince of):						
	xecute and	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a conseque	nce of):						
58760,	icate be executed physician and the burial-transit	dical		d								
_			IF FEMALE:									
Вох	eath certif attending for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal o	leath 3 🗆	Ectopic pregnan Other (specify)			23	3d. Date of delive Month	ery Day Year
P.O.	es that the death igned by the atte be detached for	hysic	1 □ Yes 2 ☑ No 9 □ Unknown	9□ Unknown								
	law requires that the death certif as been signed by the atlending 2 should be detached for use a	by	Part II. Other significant condition Corrhosis	•	out not result	ing in the ur	iderlying cause g	iven in Part I.		tobacco use Yes 2		ne cause of death? ably 4 Unknown
ecords,	aw require is been si 2 should b	Completed	Agrich	to c.					24a. Was		24b. Were auto	psy findings available mpletion of cause of
α	The ate h page	Com							perfe	2 No	death?	2□ No
Vital	Physician: The riths certificate har all director, page	Be	25. Was case referred to medical examiner?	Hospital:		D/O	-5200	thor	of Death (Check only			
of	P F F	n; To	1 ☐ Yes 2 ☐ No 27. Mann Death	28a. Date of Inju	urv 2	R/Outpatien 28b. Time of Injury	28c. lnj W	4 🔲 Nurs	sing Home 5 es 28d. Describe		Other (Specify occurred	y)
sion	or Attanding P ifter death. Director: After in by the funera	catio	1 atural 5 Pending 2 Accident investig 3 Suicide 6 Could r	jation	ly (Oat)	Injury		Yes 2 N				
Division	t Hospital or Attand 24 hours after death Funeral Director: etely filled in by the	Certification:	3 Suicide 6 Could r 4 Homicide determi	ined 288. Place of In	jury - At hom tc. (Specify)	ie, farm, stre	eet, factory, office	•		Street and wn, State)	Number or Rura	ll Route Number,
	To the Hospital or Attan within 24 hours after deal To the Funeral Director: completely filled in by the	edical (g Physician: To the best Examiner: On the basis of and manner st	of examination							
	To tha l	Me	29b. Signature and title of certifier	mla-			29c. Licer	ise number		29d. Date	signed (Month,	Day, Year)
			1/2		,27		7	1064		12	134/05	
	10 Cr		30. Name and address of person	who completed cause of a	death (Item 2	23a) (Type, I	- 3	Pt R	d Steven	erille	No	21166
	Sta Regist		31. Date filed (Month, Day, Year)	32. Regist	rar's Signatu	re H	hout s				1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registres Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3:50 PM 30 2005 RICHARD JOSEPH YANCEY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LEVINDALE GERIATRIC CTR AND HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1**X**M 2□F Director 231-58-1603 60 APR. 11, DC Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Medical Exertiner must be notified at 1 ☐ Yes 2 X No Director ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 Items 23a 1176 SUMMIT DRIVE 21409 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. illed within 72 hours after ☐Yes 2XNo 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🗶 No Specify: WHITE Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced naturel Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene.
7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) 8 LANDSCAPER LANDSCAPING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CECIL R. YANCEY **GLORIA LOUISE BROWN** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an If item 27 JAMES YANCEY/BROTHER 1176 SUMMIT DRIVE, ANNAPOLIS, MD 21409 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State ö permit. Page Department of Importent: If eny injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) CHESTERFIELD CEMETERY 01/04/2006 CENTREVILLE, MD Name and Address of Facility
ELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 21. Signature of Funeral Service Licensee 408 S. LIBERTY STREET, CENTREVILLE, MD or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part1. Enter the disease, or com shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final OVRan Physician 8 en disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 11825 Sequentially list conditions, if any, leading to limited data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): CERTI Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vest 4 Pregnant at time of death 5 Other (specify) م Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Récords, 2 X No 1 🗌 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Mellin 24a. Was an autopsy 1 Yes Division of Vital 25. Was case referred to medical examiner?

X Yes 2 □ No 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Man er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Passan Company or Attending Natural 5 Pending investigation Car Collided with another Car. 2 X No death. 2 Accident 3 Suicide Feb 19,1968 Unknown^M Director 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Roadway rince Georges County Maryland 24 hours a Funerel [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Maruni, MD 2005

Registrar

DICK

DHMH 17 Rev 1/2001

ABDOLREZA GHAZINOURI, M.D., 2434 W. BELVEDERE AVE., BALTIMORE, MD

32. Registar's Signature

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

D00601 to

State of Maryland / Department of Health and Mental Hygiene For Stete Registrer 2005-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DECEMBER 27, 2005 CHARLES ARTHUR KUMINS 12:45 P^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4701 WILLARD AVENUE, #402 CHEVY CHASE MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 6. Sex Birthplace (State or Foreign Country) 1**X** M 2□ F Director 115-09-8138 90 13, 1915 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23e or 28e-f ehr... any injury or other treumetic event, the Mentical Expension of the page 1. 10c. City. Town or Location 10a, State 10b. County 10d. Inside City Limits 1XYes 2 □ No MONTGOMERY CHEVY CHASE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4701 WILLARD AVENUE, #402 20815 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. □Yes 2 X No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: WHITE Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ CHEMIST POLYMERS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LOUIS KAMINSKI **FANNY NEGREM** 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NOEL KUMINS/DAUGHTER 4701 WILLARDS AVE., #705, CHEVY CHASE, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place)
CHESAPEAKE CREMATION
CENTER, LLC.

Date
12/30/2005 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK ROAD, CHESTER, MD 21619 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA years /Medical Due to (or as a consequence of): **Examiner** DISEASE CEREBRAL VASCULAR 4ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 28b. Time of Injury 27. Manner of Death Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 2 Accident Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/28/2005 MO 15901 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL J. GRANY / 4701 Cathedral Acrow #114w WASH DC. 20016 31. Date filed (Month, Day, Year)
DEC 2 9 2005 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,PIi,27,perMF (852,2/16/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** Calvin Jones 5:45 p Dec 14, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** Baltimore Franklin Square Hospital Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 **X**M 2 □ F Months Director 212-40-2260 Jun 28, 1941 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or then "neture!", or items 23s or 28s-f show the Medical Exemples must be notified at 1 X Yes 2 □ No Completed by Funeral Director Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 633 Cheraton Road 21225 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) t Mental Hygiene. Elementary/Secondary (0-12) Cotlege (1-4or 5+) Unknown Unknown 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be es 1 and 2 should be the Health and Menti Thelma Jones Ira Jones 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica Jones Wife 3401 Spelman Road Baltimore, Maryland 21225 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages nent of h ent: if ite 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: if eny injury or once. 12/23/05 4 Donation 5 Other (Specify) Catonsville, Maryland Metro Crematory, Inc. 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 21217 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearf failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intracranial hemorrhage /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed nding physician and use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 980 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Cocaine use peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an page 2 autopsy performed? this certificate 2□ NoX Yes of Vital After this certific funeral director, Be 25. Was case referred to medical exagniner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Yes 2 🗌 No 2 K ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Hospital or Attending 1 XNatural Injury 5 Pending death. 1 Tyes 2 □ No investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier enn St 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTO MD Zabiullah 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 4 2006 Registrar

DHMH 17 Rev 1/2001

ysician		For State Registrar	···-	aryianu / I		cate of D	ealth and N Death		Reg. No.	2003		75
		Decedent's Name (First, Middle, I		-1-				2. Date of De. Month Decembe		2 Year	3. Time of E	Death
Medical		Frances EI Facility Name (If not institution, g	izabeth Hui		4h	City Town or I	ocation of Death	Decembe		nty of Death	00:16	IVI
kaminer	40	Carroll Hospita			40.	Westmin					1 Count	- v
neral	5.	Social Security Number 6.	Sex 7. Ag	ge (In yrs. last bii			If Under 24 Hrs. Hours Min.	8. Date of Birt				
ctor	L	212-42-3186	1 M 2 F	85	Yrs.	ins Days	Hours Mill.	8. Date of Bird (Month, Da Mar 28	1920	M	lace (State or htry) D	
2 8	_	sual Residence of Decedent la. State 10b. County		10c. City, Tow	m or Location					1	0d. Inside City	Limits
once. To Be Completed by Funeral Director			ward		sville						1 ☐ Yes	
by Funeral Director	10	e. Street and Number			10	f. Zip Code			10g. Citizen	of What Cour	ntry?	
a ie		12800 Old Fred	erick Road			21784	'		USA			
ner	11	. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was E	ecedent of His	panic Origin? (Sp , Mexican, Puerto	ecify Yes or No Rican, etc.)	14. F	lace - Americ		
<u> </u>		1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X If Yes, Give Year or Dates:	No		77	Specify:		Spe		hite	
Pd be	\vdash	15. Decedent's		16a	Decedent's	Usual Occupat	ion		16h Kind of	Business/In		
Completed		(Specify only highest of Elementary/Secondary (0-12)	rade completed) College (1-4or		(Give kind o	of work done du OT use retired)	iring most of work	ing		200111000	200)	
mo:		12	College (1-401	54)	Busir	ess Own	ner		Busi	ness		
Be		. Father's Name (First, Middle, La				1	18. Mother's Nam		Maiden Sum	ame)		
2	: _	Talbott G.					Ruth					
	1	9a. Informant's Name/Relationship					nd Number or Rur					
	-20	Mr. James P. Hu	rt (Son)				erick Rd	., Sykes		, MD Z n - City or To		
		N☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control of Control				(Name of or other place) emetery	1/4/	2006		•	lle, MI)
	2	Signature of Funeral Service Lip		11L. V				_				,
1		Buand	Hugh	-	Svke	SHI FUNI Sville.	ERAL HOME	E & CHAI 84 (410)	755, PA 1-795-1	A (Box 1400	195)	
	2	3a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause	d the death. Do							Approximate Interval Between	een
1	lr d	nmediate Cause (Final	_a <u>Subdu</u>	1	ntra	Onvenc	bumal	hemat	oma		Onset and De	eath
il r	re	esulting in death)	Due to (or as	a consequence	of):	CI CVIC	- Igina	71(11/00)	07775		o nou	
	. s	equentially list conditions, any, leading to immediate	b. hype	rtensi	on_					U	unknow	377
line	if C	any, leading to immediate ause. Enter Underlying ause (Disease or injury	Due to for as	a consequence	01):							
Examiner	th re	at initiated events esulting in death) Last	c Due to (or as	a consequence	of):							
calE			d									
			- u.									
12												
Jun 1	IF 2	FEMALE: 3b. Was decedent pregnant	23c. If yes, outcome		3 □Ector	pic pregnancy			1	Date of delive	*	
sician/	IF 2	3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No		2 Fetal death		pic pregnancy or (specify)			1	Date of delive	ery Day Ye	ar
Physician/Med		3b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 □Live birth 4□ Pregnant a 9□ Unknown	2 ☐ Fetal death t time of death	5 🗆 Othe	r (specify)	s in Part I	23a Did to	'	Month	Day Ye	
۾	1	3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown art II. Other significant conditions	1 □Live birth 4□ Pregnant a 9□ Unknown contributing to death b	2 ☐ Fetal death t time of death	5 🗆 Othe	r (specify)	in Part I,		obacco use co	Month	Day Ye	ath?
۾	1	3b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 □Live birth 4□ Pregnant a 9□ Unknown contributing to death b	2 ☐ Fetal death t time of death	5 🗆 Othe	r (specify)	in Part I,	1 🗆 1	obacco use co ∕es 2 □ No	Month ontribute to th 3 □ Prob	Day Ye	ath? known
۾	1	3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown art II. Other significant conditions	1 □Live birth 4□ Pregnant a 9□ Unknown contributing to death b	2 ☐ Fetal death t time of death	5 🗆 Othe	r (specify)	in Part I.	1 🗆 Y	obacco use co 'es 2 No	ontribute to the second of the	Day Ye se cause of dea ably 4 Mun psy findings av npletion of cau	ath? known vailable
Completed by		3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown urt II. Other significant conditions	1 □Live birth 4□ Pregnant a 9□ Unknown contributing to death b	2 ☐ Fetal death t time of death	5 🗆 Othe	ing cause given		24a. Was autop perfo	obacco use co yes 2 No an 241 sy med? 2 No	ontribute to the second of the	Day Ye	ath? known vailable
Be Completed by	29	3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown art II. Other significant conditions NON € Known 5. Was case referred to medical examiner?	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown contributing to death b	2 ☐ Fetal death t time of death out not resulting i	5 ☐ Othe	ing cause given	26. Place of Deat	24a. Was autop perior 1 Yes	obacco use co	ontribute to the 3 Probe. Were autoprior to cordeath? 1 Yes	Day Ye se cause of dea ably 4 Youn psy findings available tion of cau	ath? known vailable
To Be Completed by		3b. Was decedent pregnant in the past 12 months? 1	Hospital: 1 Inpatie	2 Fetal death t time of death out not resulting i	5 ☐ Othe	ing cause given	26. Place of Deat 4 □ Nursing Ho at	24a. Was autop perior 1 Yes	obacco use co	ontribute to the second of the condition	Day Ye se cause of dea ably 4 Youn psy findings available tion of cau	ath? known vailable
To Be Completed by		3b. Was decedent pregnant in the past 12 months? 1	Hospital: 28a. Date of Inju	2 Fetal death t time of death out not resulting i	5 ☐ Othe	ing cause given DOA Other 28c. Injury a Work?	26. Place of Deat 4 □ Nursing Ho at	24a. Was autop period 1 Tyes h Check only o	obacco use co	ontribute to the second of the condition	Day Ye se cause of dea ably 4 Youn psy findings available tion of cau	ath? known vailable
To Be Completed by		3b. Was decedent pregnant in the past 12 months? 1	Hospital: 1 Inpation (Month, Da	2 Fetal death t time of death out not resulting i	5 ☐ Other I the underly Itpatient 3[Time of Injury M	ing cause given DOA Cther 28c. Injury a Work? 1 Ye	26. Place of Deat 4 □ Nursing Ho at as 2 □ No	24a. Was autop period 1 Tyes h Check only o me 5 Thesic 28d. Describe h	obacco use co	Month ontribute to the second of the second	Day Ye Day Ye	ath? known vailable use of
Certification: To Be Completed by	2:	3b. Was decedent pregnant in the past 12 months? 1	Hospital: 1 Inpation (Month, Date of Injudent) 28a. Date of Injudent) 28a. Date of Injudent) 28a. Place of Injudent) 28a. Place of Injudent)	2 Fetal death t time of death but not resulting i ent 2 FR/Ou try y Year) 28b. jury - At home, fa ic. (Specify)	5 ☐ Other Ithe underly Ithatient 3 ☐ Time of Injury Marm, street, far	DOA Other 28c. Injury a Work? 1 Ye ctory, office	26. Place of Deat 4 □ Nursing Ho at as 2 □ No	24a. Was autop performent of the control of the con	obacco use co	Month ontribute to th 3 □ Prob b. Were auto prior to cordeath? 1 □ Yes Other (Specifications)	Day Ye Le cause of del ably 4 VIUI psy findings available from of cau 2 No	ath? known vailable use of
Certification: To Be Completed by	2:	3b. Was decedent pregnant in the past 12 months? 1	Hospital: 28a. Date of Inju (Month, Date of Inju (Month, Date of Inju (Month) and Date of Inju (Month) on the Date of Inju (Month) on the Date of Inju (Month) on the Date of Inju (Month) on the Date of Inju (Month) on the Date of Inju (Month) on the Date of Inju (Month) on the Date of Inju (Month) on the Date of Inju (Month) on the Date of Inju (Month) or the Dat	2 Fetal death t time of death out not resulting i out not resulting i out not resulting i out not resulting i out not resulting i out not resulting i out not resulting i out not resulting i out not resulting i	5 ☐ Other In the underly In the underly It patient 3 ☐ Time of Injury Marm, street, far e, death occur A death occur B. death occur	DOA Cther. 28c. Injury a Work? 1 Ye ctory, office	26. Place of Deat 4 □ Nursing Ho at as 2 □ No	24a. Was autop performent of the control of the con	obacco use co	Month ontribute to the second of the second	Day Ye	ath? known vailable use of
To Be Completed by	2:	3b. Was decedent pregnant in the past 12 months? 1	Hospital: 1 Inpation (Month, Date of Injudent) 28a. Date of Injudent) 28a. Date of Injudent) 28a. Place of Injudent) 28a. Place of Injudent)	2 Fetal death t time of death out not resulting i out not resulting i out not resulting i out not resulting i out not resulting i out not resulting i out not resulting i out not resulting i out not resulting i	5 ☐ Other In the underly In the underly It patient 3 ☐ Time of Injury Marm, street, far e, death occur A death occur B. death occur	DOA Cther. 28c. Injury a Work? 1 Ye ctory, office	26. Place of Deat 4 Nursing Ho at as 2 No , date and place, nion, death occur	24a. Was autop period 1 Yes h Check only o me 5 Reside 28d. Describe h 28f. Location (\$ City or Toward and due to the cred at the time, the second se	obacco use co	ontribute to the street of th	Day Ye Day Ye Day Ye Day Ye Day Ye The cause of delate and the cause (s)	ath? known vailable use of
Certification: To Be Completed by	2:	3b. Was decedent pregnant in the past 12 months? 1	Hospital: 28a. Date of Inju (Month, Date of Inju (Month, Date of Inju (Month) and Date of Inju (Month) on the Date of Inju (Month) on the Date of Inju (Month) on the Date of Inju (Month) on the Date of Inju (Month) on the Date of Inju (Month) on the Date of Inju (Month) on the Date of Inju (Month) on the Date of Inju (Month) on the Date of Inju (Month) or the Dat	2 Fetal death t time of death out not resulting i out not resulting i out not resulting i out not resulting i out not resulting i out not resulting i out not resulting i out not resulting i out not resulting i	5 ☐ Other In the underly In the underly It patient 3 ☐ Time of Injury Marm, street, far e, death occur A death occur B. death occur	ing cause given DOA Other 28c. Injury a Work? 1 Ye ctory, office rred at the time attion, in my opin 29c. License I	26. Place of Deat 4 Nursing Ho at as 2 No , date and place, nion, death occurronumber	24a. Was autop period 1 Yes h Check only o me 5 Resid 28d. Describe h 28f. Location (\$ City or Toward and due to the cred at the time, the second sec	obacco use covers 2 No an 24l sy rmed? 22 No lence 6 Covers injury occurry cause(s) and date and place 29d. Date sig	Month 3 □ Prob b. Were auto prior to cor death? 1 □ Yes Other (Specification of Rura manner as stee, and due to	Day Ye Day Ye Day Ye Day Ye Day Ye The cause of delate and the cause (s)	ath? known vailable use of
Certification: To Be Completed by	2:	3b. Was decedent pregnant in the past 12 months? 1	Hospital: 1 Inpatie 28a. Date of Injuidenth, Da 28e. Place of Injuiding, el	2 Fetal death time of death but not resulting if the part of the p	stpatient 3□ Time of njury Marm, street, fare, death occurred or investige.	ing cause given DOA Other 28c. Injury a Work? 1 Ye ctory, office rred at the time attion, in my opin 29c. License I	26. Place of Deat 4 Nursing Ho at as 2 No , date and place, nion, death occur	24a. Was autop period 1 Yes h Check only o me 5 Resid 28d. Describe h 28f. Location (\$ City or Toward and due to the cred at the time, the second sec	obacco use co	Month 3 □ Prob b. Were auto prior to cor death? 1 □ Yes Other (Specification of Rura manner as stee, and due to	Day Ye Day Ye Day Ye Day Ye Day Ye The cause of delate and the cause (s)	ath? known vailable use of
Certification: To Be Completed by	2:	3b. Was decedent pregnant in the past 12 months? 1	Hospital: 1 Inpation 28a. Date of Inju (Month, Da 28e. Place of Inju be do 28e. Place of Inju be aminer: On the basis of and manner st	2 Fetal death time of death but not resulting if the part of the p	stpatient 3□ Time of njury Marm, street, fare, death occurred or investige.	DOA Other 28c. Injury a Work? 1 Ye ctory, office rred at the time ation, in my opin 29c. License I	26. Place of Deat 4 □ Nursing Ho at as 2 □ No date and place, nion, death occur number 005483	24a. Was autop performed to the control of the cont	obacco use co	Month 3 □ Prob b. Were auto prior to cordeath? 1 □ Yes Other (Specification of Rura manner as site, and due to	Day Year) Day Year)	ath? known vailable use of
Medical Certification: To Be Completed by	2: 2: 2: 3: ()	3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significant conditions III. O	Hospital: 1 Inpatii 28a. Date of Inju (Month, Date) be 28e. Place of Inju (Month, Date) contributions to the basis of and manner st	2 Fetal death time of death but not resulting in the part of the p	stpatient 3€ Time of Injury Marm, street, fa	DOA Other 28c. Injury a Work? 1 Ye ctory, office rred at the time ation, in my opin 29c. License I	26. Place of Deat 4 Nursing Ho at as 2 No , date and place, nion, death occurronumber	24a. Was autop performed to the control of the cont	obacco use co	Month 3 □ Prob b. Were auto prior to cordeath? 1 □ Yes Other (Specification of Rura manner as site, and due to	Day Year) Day Year)	ath? known vailable use of
Certification: To Be Completed by	2: 2: 2: 2: 3: ()	3. Was case referred to medical examiner? 1 Nes 2 No 9 Unknown art II. Other significant conditions 1 Ne Known 5. Was case referred to medical examiner? 1 Nes 2 No 7. Manner of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could not 4 Homicide determine 9a. Certifier (Check only 2 Medical Example) 9b. Signature and title of certifier 0. Name and address of person	Hospital: 1 Inpation 1 Inpation 28a. Date of Injundading, else aminer: On the basis of and manner stop 1 Inpation 2 Input Inpu	2 Fetal death time of death time of death but not resulting in the control of the	stpatient 3€ Time of Injury Marm, street, fa	DOA Other 28c. Injury a Work? 1 Ye ctory, office rred at the time ation, in my opin 29c. License I	26. Place of Deat 4 □ Nursing Ho at as 2 □ No date and place, nion, death occur number 005483	24a. Was autop performed to the control of the cont	obacco use co	Month 3 □ Prob b. Were auto prior to cordeath? 1 □ Yes Other (Specification of Rura manner as site, and due to	Day Year) Day Year)	ath? known vailable use of

DHMH 17 Rev 1/2001

Physic	cian	1 - Staiment# 30 Per Registrar 1. Decedent's Name (First, Mic	Phy. 2/14/06		Cei	tificate	of H	eaith a Death	ana M	-	Reg. No	200	5 - 'ear	438 3. Time of	76 Death
/Med Exam	ical	Raymond 4a. Facility Name (If not institut 2 Cambrills I	ion, give street and num		Burkt	ardt 4b. City, To Seve		Location o	of Death	12-25-05	4c	. County of	Death	6: 00	ΑM
Funera Directo	_	5. Social Security Number 215–40–9132 Usual Residence of Decedent	6. Sex 1 → M 2 → F	7. Age (In yrs. last bir 63	thday) Yrs.	If Under 1 Months	Year Days	If Under a		8. Date of Birt (Month, Da March 2	y, Year)		Birthp Cour aryl	ilace (State o htry) and	r Foreign
e Maryland 3a-f ehow	ctor	10a. State 10b. Coun	rundel	10c. City, Tow	n or Lo	cation							1	0d. Inside Ci	ity Limits
ath with the 23a or 23	Funeral Director	10e. Street and Number 2 Cambrills Roa				10f. Zip C	4				USA	tizen of Wh	at Cour	itry?	
1215-UU36 within 72 hours after death with the Maryland ane. than "netural", or items 23a or 28a-f show the Madical Examinat must be notified at	5	11. Marital Status 1 □ Never Married 2 ★ Mi 3 □ Widowed 4 □ Divorce	Armed For	2 X No		Was Decede f Yes, specify I ☐ Yes 2	4.0	spanic Origin, Mexican, Specify:	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	-	14. Race - Black, Specify:	White,	etc.	
Maryland 21213-UU30 nd 2 should be filed within 72 hours af lith and Mental Hygiene. 27 is marked other than "natural", or r traumatic event, Ira Madical Exam	Completed	15. Decedi (Specify only high Elementary/Secondary (0-12	ent's Education lest grade completed) College (1-	40r 5+)	(Give life. L	lent's Usual kind of work DO NOT use Cal En	done di retired)	uring most	of working	g	16b. K	ind of Busin	ness/ind	dustry	
styland Z should be filed nd Mental Hygi marked other umatic event, I	To Be C	17. Father's Name (First, Middle Leo Burkhardt						Adelaio	de D						
the Head		19a. Informant's Name/Relation Stephen R. Burkh 20a. Method of Disposition 1 X Burial 2 □ Cremation	andt (son)	20b. Place of	00] Dispos	Burkhan sition (Name natory or other	dt] of er place	Lane, S	Seven	Route Number n, MD 211 ate 2005	20c. Lo	or Town, Sta ocation - Cit Burnie	ty or To		
Daltimore, permit. Pages 1 ar Department of Hea Important; if itam eny injury or othe		4 □ Donation 5 □ Other 21. Signature of Euneral Service		/ GIGITIE	22	. Name and	Address	s of Facility	Harde	sty Fune dis, MD	ral I	Home, I	,		
Physician /Medical Examiner sthe privalent and physicien and sthe prival-transit	Examiner	23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	used the death. Do not line. Challes to the sequence of as a consequence of as a consequence of as a consequence of the sequence f):									Approximate Interval Bets Onset and E	ween	
The faw requires that the death certificate the has been signed by the attending physpage 2 should be detached for use as the	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live bir	ome of pregnancy th 2 ☐ Fetal death nt at time of death wn		Ectopic preg Other (spec						23d. Date o Month			'ear
w requires that in the second by should be detailed.	b	Part II. Other significant condi	tions contributing to dea	ath but not resulting in	the un	derlying cau	se giver	n in Part I.		23e. Did to		_		e cause of de	
vital necor icien: The law requ certificete has been rector, page 2 shoult	Completed							-		24a. Was a autops perfor	SV	24b. Wer prio deal 1 [r to con th?	osy findings a apletion of ca	vailable iuse of
tending Physeath. cor: After this the funeral di	Certification: To Be	3 Suicide 6 Couk	Hospital: 1 In In 28a. Date of (Month tigation 1 not be 28a. Place of 1 not be 28a. Place o	, Day Year) tr	ime of njury	28c	Other Injury : Work? 1 Ye	4 □ Nurs	sing Hom 28	Check only or e 5 X Reside	ence 6	y occurred			
Hospital or At 24 hours after of Funerel Direct tely filled in by		29a. Certifier 1 Y Certify	building	of Injury - At home, failing, etc. (Specify) est of my knowledge	. death	occurred at	the time	e, date and	place ar	If. Location (Si City or Town	n, State)	and manns	e 20 010	atad	
To the Hospital within 24 hours a To the Funerel Completely filled	Medical	29b. Signature and title of certification	er	or stated.	Z/or inv	29c. L	icense	nion, death	occurred	d at the time, d	ate and	place, and e signed (A 28-05	due to	the cause(s)	
St Regist	ate	30. Name and address of person Pallari Kumar, 31. Date filed Worth, Day, Yea	MD, Sinai Hos	pital 2401 W	Туре, Р Л. Ве	Print) Livedere	e Ave	.,Balt	imore	, MD					

		1 - For Amend Items 2 Registrar	State of M 3a,25 per Pt II	ME,C	852 <u>0</u>	artmen Hilicat		ealth a Death	and M	iental Hy	giene Reg. No.	200	5-4387
Di-		Decedent's Name (First, Middle, Las								2. Date of De Month	ath Day	y Year	3. Time of Death
Physic /Med		Elizabeth	K		_	Burge	ener			12-29	-200)5	2:20 P
Exami		4a. Fecility Name (If not institution, give	street and number	r)		4b. City,	Town, or	Location of	of Death		4c.	County of Deat	th
		Crofton Convalesc			last birthday)	+	Crof		24 Hrs	8. Date of Bir	th	Anne An	undel hpface (State or Foreig
Funeral Director			M 2,5,1	88	Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)	Co	npiace (State of Poreig ountry) ndiana
		Usual Residence of Decedent		00						9-20-1	. 711		lulana
72 hours after death with the Maryland naturel; or Itams 23a or 28a-f ehow digal Exemitiver must be notified at		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City Limit
a-f-	cto	MD Anne A	rundel	Cro	fton								1 ☐ Yes 24∰2N
17 th	Director	10e. Street and Number				10f. Zip	Code				10g. Citi	izen of What Co	ountry?
238	a	2131 Davidsonvill			-		114	7				S.A	
ous after Death with the Marylar Fair, or trams 23e or 28e-(e how Exercitest mast be notified at	Funerai	11. Marital Status	12. Was Deceden Armed Forces 1 ☐ Yes 2 ②	\$?		Was Deced	dent of Hi city Cuba	spanic Ori n, Mexican	gin? (Spi i, Puerto	ecify Yes or No Rican, etc.))-	 Race - Ame Black, White 	
L'or	by F	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates			1 🗆 Yes	2 🛛 No	Specify:				Specify: Whi	ite
"natural", valical Ex		15. Decedent's Ed	ucation		16a. Dece	dent's Usua	al Occupa	ation			16b. Ki	nd of Business/	Industry
c *_ 24	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) Coltege (1-4o	r 5+)	(Give	kind of wo DO NOT u	ork done d se retired	luring most)	t of worki	ng			
	E O	12		,	Home	naker					C	wn Home	<u> </u>
B	Be	17. Father's Name (First, Middle, Last)								(First, Middle,	. Maiden	Sumame)	
	2	Joseph A. Luyben						Sara	h Bl	eeker			
and and		19a. Informant's Name/Relationship (7	• •		1	•						r Town, State, 2	Zip Code)
lee T		Mr. David Burgene	r / Son	OOL D	6108			rive;		ferson,			
なっここ		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from Stat	e C	emetery, cre	matory`or o	other place	1		Date		cation - City or	
	1.	14 □ Donation 5 □ Other (Specify		Gle	n Have							n Burni	
permit. Departr Importe any inji		21. Signature of Funeral Service Licen:	See // /	Mai	n / 1					_		eral Ho	
10240		23a. Part1. Enter the disease, or comp	Y) Carlo	1 1013	W							MD 2106	Approximate
		shock, or heart failure. List only of	one cause on each	line.	1. Do not em	iei ine mod	Je or dying	, such as	Cardiac	л төзрпацогу аг	11651,		fnterval Between Onget and Death
hysician /Medical		disease or condition resulting in death)	a. <u>Se</u>	ps	15					·			days.
xaminer			Due to (or a	spa consequ	vence or):	ah	at	4 4	L			1	
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consequ	uence of):	3 /	, 01 1	$\frac{1}{2}$		1	1		7200
d	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	Der	mon	ntio	7			1	m/	CAL EXAM	INER	4 Par
en an rial-tr		resulting in death) Last	Due to (or a	s a consequ	uence of):			1	JAPP!	ROVED BY MEDI			7
ohysicien and the burial-transit	dical		d					CERTIFICA	UOI	M. ROVED BY MEDI			
ng pt as ti	Med	tF FEMALE:											
attending p	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 Fetal	death 3	∃Ectopic pr					2	23d. Date of defi Month	ivery Day Year
by the al	Sici	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant: 9□Unknown	at time of de	eath 5	Other (sp	ecify)						July Vou
ed by		Part ff. Other significant conditions co	entributing to death	but not resu	ulting in the u	nderlying c	ause dive	n in Part I		23e Did to	obacco u	se contribute to	the cause of death?
signe d be	d by	Panablea	_		spinal	, ,	•			101		ZNo 3□Pr	
peen si	ete	Osteoarthri						<i>.</i>		040 1450			Anna dindina avalah
2 5 6	Completed		.610		· ·					24a. Was autop perfo	sy	prior to death?	topsy findings available completion of cause of
		05 146								1 ☐ Yes	2 NO	1 ☐ Yes	2 No
Cert rect	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpat	tient 2 🗆	ER/Outpatier	y 20 00	Othe			Check only o			7.6.1
or this eral di	. To	27. Manner of Death	28a. Date of In (Month, D		28b. Time o		28c. Injury Work	4-M MIII		ne 5∐ Resid 28d. Describe h		Other (Spec	ату)
to the nospitel of aventing within 24 hours affer death. To the Funerel Director: Affer completely filled in by the funer	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	ay Year)	fn j ury	м		? ′es 2 □ t					
after death. Director: A I in by the fu	He	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	200. Place of II	njury - At ho	me, farm, str	eet, factory	y, office		1				ral Route Number,
s afte ei Dir	Certification:	I I GITIE GO	Duliding, 6	atc. (<i>Specif</i> y	,					City or Tow	vii, State,		
within 24 hours after de To the Funerei Direct completely filled in by th		29a. Certifier Check only Check only	sician: To the bes	of examinat	wledge, deat	h occurred	at the tim	e, date and	d place, a	and due to the	cause(s)	and manner as	stated.
in 24 the Fi	Medical	one)	and manner s	stated.	ion and/or in				, occurr				
To	Σ	29b. Signature and title of certifier		nAN	1 60	Δ 290	c. License	number	V 02%	D	29d. Date	e signed (Month	n, Day, Year)
		Karosr										2/30	
		30. Name and address of person who o	completed cause of	death (Item	23a) (Type,	Print)	1 Δ	NTI	=0×	LNH	222	BOWI	EMDO
		CHICESH A	KOKAN	4D 1	7300	SH			- 1-	- · + -n		, ,	-, 1 1 0 20/
St Regist	ate	31. Date filed (Month, Day, Year) FFR 2 1 2006	32. Hegis	trar's Signat	tura (9							
10000	12.17	T 47 ES Z1 4 / 1100	G Form' St. L.		STORES STREET								

			1 For Amend Item	State of Marylan	d/Depa	8279		Mental Hy	giene	5-42870
R.	* 杨		Registrar 1. Decedent's Name (First, Middle, Last)		Cel	lincale	or Death	2. Date of De	Reg. No. AUC ath	3. Time of Death
	Physici /Medic	al	Alvira Evangline			4b. City. T	own, or Location of Dea	Decemb	Pr 22 20	05 12:44 PM
-	Examir	ier	Washington County 1				erstown	W I	Washing	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1		8. Date of Bir	th 9. E	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	M 25 F	76 Yrs.			December	7 07,1929	PA
1215-0036 within 72 hours after death with the Maryland	rel', or iteme 23a or 28a-f ehow Examiner must be notified at	r.	10a. State 10b. County		ty, Town or Lo					10d. Inside City Limits
Ne M	-88-1 -1	ecto	MD Washing	gton Hag	erstow		2-4-		40-07	1 XYes 2 □ No
¥.	S O	by Funeral Director	333 Mill Street			10f. Zip (10g. Citizen of What	Country ?
death	E 3	era		12. Was Decedent Ever in U	J.S. 13.	2174 Was Decede	HO ent of Hispanic Origin? (fy Cuban, Mexican, Pue	Specify Yes or No	USA - 14. Race - Ar	merican Indian,
9	2 8	Fur	1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		_		rto Rican, etc.)		hite, etc.
003 0047s	= =	d by	3 Widowed 4 Divorced	Year or Dates:		1 ☐ Yes 2	X No Specify:		Specify:	Mhite
21215-0036 od within 72 hours aff	to Health and Mental Hygiene. If Item 27 is marked other than "naturel; or other traumatic event, tra Musical Exa	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual kind of work DO NOT use	Occupation done during most of wo	orking	16b. Kind of Busines	ss/Industry
12 E	then a	duic	Elementary/Secondary (0-12)	College (1-4or 5+)		emaker	,		Or m. Home	
	Hygi other ent,	Be Cc	17. Father's Name (First, Middle, Last)		ПОШ	emaker		me (First, Middle,	Own Home Maiden Sumame)	
lan di be	henta rked ilc ev	To B	Mac K. Pittman,	Sr.			Amber 1	. Younke	er	
Maryland	and N	_	19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Mailir	ng Address	Street and Number or F	lural Route Numbe	er, City or Town, State	, Zip Code)
E 6	またま		Mac K. Pittman, J		354	Pennsy	lvania Aver	nue Hanco	ock, MD 21	750
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R		Place of Dispo cemetery, crer	sition (Name matory or oth	e of ner place)	Date	20c. Location - City	or Town, State
iii a	tant:		4 □ Donation 5 □ Other (Specify)	Sm	ithsbu	re Cre	Address of acility	29/05	mithsbur	, MD
Baltimore	Department of Heal Important: if Item 2 any Injury or other once.		21. Signature of Funeral Service License	° el				TAT ME	est Main S	
			220 Port 1 Enter the disease or comedi) Know	G:	rove F	uneral Home	e, P.AHa	ancock, MD	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	cause on each line.	in. Do not ent	er the mode	or dying, such as cardia	ic or respiratory a	rrest,	Approximate Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	Complication		Chok	T			
-	xaminer			Due to (or as a consec	quence of):		O	. /	,	- 11
	聚 .	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	quence or):			11/	ER	
petno	ld ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				D.M	MEDICAL EX	KAMII	
, , ,	ysicien and he burial-transit		resulting in death) Last	Due to (or as a consec	quence of):		CERTIFICATION			i .
8760,	physic the b	dical					CERTITIO			
of Vital Records, P.O. Box 68760, Physician: The law requires that the death certificate be executed	ed by the attending physidetached for use as the t	Physician/Medi	in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3	Ectopic pre Other (spe			23d. Date of d Month	lelivery Day Year
P.O.	d by ti etach	Phy	9 Unknown					1		
Division of Vital Records,	an signed l	Completed by	Part II. Other significant conditions con	Fa. lane	sulting in the ui	nderlying ca	use given in Part I.		obacco use contribute Yes 2 No 3	to the cause of death? Probably
O ×	2 sho	piet	Dementia					24a. Was		autopsy findings available
E P	ate h	E O	Rlounatois As	the it,				autop perfo	med? death	
/ita	ertific ector,	Be	25. Was case referred to medical examiner?				26. Place of De	ath (Check only o		
J. hyei	this o	၉	Yes 2□No		ER/Outpatier				dence 6 Other (Sp	pecify)
on o	After	o E	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 12/22/05	28b. Time of		c. Injury at Work?		on food	
isic	death ctor: v the	Certification:	Accident investigation 3 Suicide 6 Could not be	1	Noon	M cat factors	1 ☐ Yes ₹ No		Street and Number or	Devel Posts Name
Div	after Dire	erti	4 Homicide determined	28e. Place of Injury - At h. building, etc. (Specil nursing home	fy)	eet, lactory,	onice	Julia M	anor Healt	h Care Ctr.
spita	naral naral fille		29a. Certifier 1 Certifying Phys	ician: To the best of my kno	owledge, death	occurred a	t the time, date and place	e, and due to the	cause(s) and manner	agerstown, MD
Division To the Hospital or Attending	within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should	Medical	(Check only one) Medical Examin	er: On the basis of examina and manner stated.	ation and/or in	vestigation, i	n my opinion, death occ	urred at the time,	date and place, and d	ue to the cause(s)
5	To to	Σ	29b. Signature and title of certifier			29c.	License number		29d. Date signed (Mo.	nth, Day, Year)
			DAD MD, FAC.	ee		(0056965		DOC 28.	2005
			30. Name and address of person who co		m 23a) (Type,	Print))0056965 ge.stown		/ -	
	20.000		Stephen Kotch 25 31. Date filed (Month, Day, Year)	1 E. Antisten	n 5+.	Ha	ge, stown	mo 2,7	77	
	Sta Registi		FEB 2 1 2006	32. Registrar's Signa	A STATE OF THE STA	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23 1410 of Maryland / Department of Health and Mental Hygiene I, II, 25, 27, 28a-L per Me, 6852, 02/17/06dhb Gertificate of Death Reg. No. 1 - For All State Registrar 1. Decedent's Name (First_Middle, Last) 2. Date of Death Month / 2 Day Year **Physician** 3 0 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kose dAl BAITIMORE 7. Age (In yrs. last birthday) SQUARE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Jonth, Day, 5. Social Security Number 6. Sex. 1 M 2 ☐ F Birthplace (State or Foreign Country) **Funeral** Months Days Hours 212-60-3960 Usual Residence of Decedent 50 Director 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits and Mental Hygiene.
In marked other than "natural", or items 23a or 28a-f show
in marked other than "natural", or items 23a or 28a-f show
raumatic event, the Madical Examinar must be notified at Baltimore 1 Yes 2 No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2122 1152 rive by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No IFY'S, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Black Specify: Specify: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of york done during most of working life. DO NOT use retired 15. Decedent's Education 16b. Kind of Business/Industr (Specify only highest grade completed) Elementary/Secondary (0-12) Cellage (1-4or 5+) Cooter Son **XYrs** or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Midd permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any july or other traumatic event song injury or other traumatic event song. Be lossie maerson 2 19b. Mailing Aq ress (St. e-t and Number or Ru-I Route Number, City or Town, State, Zip Code) Balti more, ler 1152 Hunjab I 20a. Method of Disposition 20c. Location · City or Town, State Burial 2 Cremation
Donation 5 Other (5 3 Removal from State 21. Single of Figeral Service Lice See rownsville Greene Funeral Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line. Ustown, MD 21132 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SepTic **Physician** Shock /Medical Due to (or as a consequence of) Examiner b. Mehicillin 545 C Sus ceptible Staphylozoccus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ATTON APPROVED BY MEDICAL EXAMINER Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical CERTIF IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Hepalilis B+C 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? PERITON SPONTANEOUS BACTERIAL Endstage liver disease, Acute renal failure 2 No 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2200 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Division 2 Accident 5 Pending efter death. subject fell 12/7&9;2005 1 ☐ Yes 2 No Unknown M investigation filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) at home 28f. Location (Street and Number or Rural Route Number, 4 | Homicide 1152 Punjab Drive, Baltimore, MD vithin 24 hours of To the Funeral D completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Pi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title cep 29c. License number 29d. Date signed (Month, Day, Year) D28717 -30-2005

Registrar

FEB 2 1 2006

31. Date filed (Month, Day, Year) 32. Registrar's Signature

1000 FRAUKLIA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SpiLLE DK.

DA LINGKE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25tate of Maryland Penariments 1491 and Annial Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Esther K. Zemil Year **Physician** DECEMBER 2005 /Medical 12 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MORTHWEST HOSPITAL RANDALLS TOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. JAN.1, 1918 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1□M 2\ F 87 Yrs. NY 212-03-1614 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location rthen "natural", or Iteme 23s or 28s-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21117 4730 ATRIUM COURT #602 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗖 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE à Specify: 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Health and Z should be fill Health and Mental H tem 27 le marked ott RICHMOND KAY SADIE ISIDOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 BARBARA NYSETER / DAUGHTER 31 AUSTRINGER COURT - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If its
eny injury or ot
once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5. ☐ Other (Specify) BETH TFILOH CEMETERY 12/15/2005 WOODLAWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. prvice Licensee 21. Signature of Pure 31 W 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hyart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cayse (Final disease or condition resulting in death) **Physician** subdural hemetoma /Medical Due to (or as a consequence of): Examiner PROVED BY EDICAL ATTHIER Sequentially list conditions, tany leading of in neciale cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner M The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hip fracture 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 No 1 Yes 2 No Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 25 No. 2 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification Injury 5 Pending death. 2X Accident 12/11/05 1 ☐ Yes X No Subject fell investigation 1 p. M Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office at building etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide 4730 Atrium Ct., #602 Mills, MD 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Medical

(Check only one)

29b. Signature and title of certifier

Baltimore, Maryland 21215-0036

Ö

Records,

Division of Vital

31. Date filed (Month, Day, Year) FEB 2 1 2006

Durton

mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

> MO NOR HWEST 32. Registrar's Signature Sports 1

D0059736 December 12, 2005 HOLL AL S-U OLD COULT

29d. Date signed (Month, Day, Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Registrar

g852 2/23/06 KBH
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 5-22 per F.H. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2005 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** GILCHRIST EMMANUEL /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5/14/05 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number in L 7. Age (In yrs. last birthday) **Funeral** Days **₩** M 2□F Md. Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Yes 2 No Director Md. Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 3414 Dolfield Ave. 21215 USA death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Item any injury or other traumatic event, Ite Medical Education. Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: Never Married 2 Married **Black** Baltimore, Maryland 21215-0036 1 ☐ Yes 🛣 No Specify: 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Infant Infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edwin Horace Gilchrist Sherreyl Macer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3414 Dolfield Ave. Baltimore, Md. 21215 Sherreyl Macer (mother)
Oa. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 6/2/05 * 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PREMATURIT Physician MIN /Medical Due to (or as a consequence of) Examiner Saquentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, physician use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. detached 9 Unknown 05 cate has been signed , page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 12 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 La patient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending to Funeral Director: Af sletely filled in by the fun 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MI D 20998 e and address of person who completed cause of death (Item 23a) (Type, Print) CALVERT ST. 315 N. ULIAN EMERSON 31. Date filed (Month, Day, Year) 32. Régistrar's Signature

Registrar

amend 24a,25 per Dr. g853 3/2/06 KBH Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State Registrar Decedent's Name (First, Middle, Las	st)	Certifica	te of Death	Reg. 2. Date of Death		4.08.0 3 3. Time of Death
Physici		2100				Month OCT	Day Year 11 200 5	3:55 p
/Medic Examin		4a. Facility Name (If not institution, give	Achenbach a street and number)	4b. Cit	y, Town, or Location of Dea		4c. County of Death	
		Holy Cross He			lver Spring		Montgomer	
Funeral Director			ex 7. Age (In yrs. ☐ M 2 🖫 F	Vrs. If Und	ler 1 Year If Under 24 Hrs s Days Hours Min		9. Birth Co.	place (State or Foreigntry) MD
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show surmatic event, the Medical Examples found the multiled at		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limit
rs atter death with the Marylar ', or items 23a or 28a-f ahow canting round by notified at	ctor	VA Loude	oun A	shburn				1 ☐ Yes 2 ☐ ☆
or 28	Funeral Director	10e. Street and Number		10f. Z	Zip Code	10g.	Citizen of What Cor	untry?
8 23e	erai	21325 Small Brand	ch Road 12. Was Decedent Ever in U	S 13 Was Dec	20148	Specify Ves or No-	USA 14. Race - Amer	ican Indian
E I	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ X o		edent of Hispanic Origin? (pecify Cuban, Mexican, Pue	no Rican, etc.)	Black, White	, etc.
Exa	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 L Yes	No Specify:		Specify: Wh	ite
dical	Completed by	15. Decedent's Ec (Specify only highest gra	lucation de completed)	16a. Decedent's Us (Give kind of w	sual Occupation work done during most of wo use retired)	orking 16t	o. Kind of Business/l	ndustry
the Medi	duic	Elementary/Secondary (0-12)	College (1-4or 5+)	n /a			Infant	
event, I	Be Co	17. Father's Name (First, Middle, Last)		11 / 6		ame (First, Middle, Mai		
tic ev	To B	Mark Allen Achenba	ach		Tiffan	y Rocha		
7 la marke traumatic	,-	19a. Informant's Name/Relationship (1	ss (Street and Number or F			
m 27 her ti		Tiffany R. Achenb	ach -Mother	21325 Sma	11 Branch Rd	., Ashburn	VA 2014 . Location - City or 1	
or of		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	emetery, crematory or	r other place) Funeral 10/2	17/2005		
Important: If its any injury or ot once.		*4 □Donation 5 □ Other (Specifical Service Licer			and Address of Facility	17/2005	Herndon,	VA
any and	l d) (han /	Han	Adam	s-Green Fune Elden St.,	ral Home		
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat	h. Do not enter the mo	ode of dying, such as cardia	ac or respiratory arrest,		Approximate Interval Between
sician		Immediate Cause (Final disease or condition		remeterity	1			Onset and Death
edical miner		resulting in death)	Due to (or as a conseq		1		4	,
e e	100	Sequentially list conditions,	b. Victoria	PROM				
insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Date to for the direction	la bac				
rial-tra	Exai	that initiated events resulting in death) Last	Due to (or as a conseq			,	1	
he burial-transit	Icai		a Tula to	Twin trans	stusion Synd	rone with	. Selective	Reduction
e as t	Physician/Medi	IF FEMALE:						
attending phy for use as the	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of d	I death 3 Ectopic			23d. Date of deliment	very Day Year
detached	iysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	eath 3 Chief (specify	-	10	1 65
d be deta	by Pt	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
should b						1 ☐ Yes	2 2 No 3 □ Pro	bably 4 Unknow
N	ompleted					24a. Was an autopsy	prior to c	opsy findings availat
pai	Соп					performed 1 ☐ Yes 2 €		2 ☑ No
is certificate hi director, page	Be	25. Was case referred to medical examiner?	Hospital:		Other	eath (Check only one)		
r this oral dii	1: To	1 Yes 2 No	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 1 28b. Time of	28c. Injury at	Home 5 Residence		rfy)
r: After e funer	ation	1 Katural 5 ☐ Pending 2 ☐ Accident investigation		Injury M	Work? 1 ☐ Yes 2 ☐ No			
in by th	Certification:	3 Suicide 6 Could not b 4 Homicide determined		ome, farm, street, factory)	ory, office	28f. Location (Stree City or Town, S	t and Number or Ru Itate)	ral Route Number,
completely filled in by the		29a. Certifier 1 Certifying Pt (Check only 2 Medical Exar	nysicien: To the best of my kno niner: On the basis of examina	owledge, death occurre	ed at the time, date and place	ce, and due to the caus	e(s) and manner as	stated.
To the Funeral Director: After this certifics completely filled in by the funeral director, I	Medical	one) 29b. Signature and title of certifier	and manner stated.		9c. License number		Date signed (Month	
- 8		A D M	MA		5 44086	230.	10/11/05	,,
		20 Name and address of payman was	completed cause of death (Iter	n 23a) (Type Print)	- 1,000		((((0)	
		30. Name and address of beison were						

		1 - State Registrar		,		artment of F tificate of				Reg. No.		5	4355-
Dhusis		1. Decedent's Name (First, Middle	, Last))			2. Date of D			ear	3. Time of Dear
Physic /Med		Thouston	LA	shaw	13 J	Sceder			5	13		55	3:45
Exami	iner	4a. Facility Name (If not institution,	give street and r	number)		4b. City, Town, o	or Location o	f Death		4c.	County of	Death	
		5. Social Security Number	6. Sex	7. Age (In yrs. I	last hirthday)	If Under 1 Year	If Under		8. Date of Bi	idh		Diethol	Isaa (Stata or For
Funeral Director		Tofa.+	1□M 2/KIF		Yrs.	Months Days	Hours 5	Min.	(Month, D	ay, Year)	_	Count	lace (State or For try)
		Usual Residence of Decedent							O /6	2 00	2		11.5
arylar	Ę	10a. State 10b. County		10c. City	/, Town or Loc							10	Od. Inside City Lin
8e-f	Director	MD			13a1	Timore			· · · · · · · · · · · · · · · · · · ·				1 Yes 2
a or a	ä	10e. Street and Number	1	01		10f. Zip Code	_			10g. Citi	izen of Wha		try?
n 72 hours after death with the Marylan "natural", or items 23a or 28e-f show clical Examiner mast be notified at	by Funeral	2001 13A	_	ecedent Ever in U.	S. 13. V	Vas Decedent of H	dispanic Orio	in? (Spec	ify Yes or N	0=	14. Race -		an Indian
riter in	Fun	1 Never Married 2 Marrie	Armed ed 1 ☐ Ye	Forces?	1 _	Vas Decedent of H f Yes, specify Cubi		Puerto F	Rican, etc.)			White, e	
ral', c		3 Widowed 4 Divorced	II Y es.	Give Dates:	1	I□Yes 2□XIO	Specify:				Specify:	B	lack
72 h	Completed	15. Decedent' (Specify only highest		d)	(Give)	lent's Usual Occup kind of work done	during most	of workin	a	16b. Ki	ind of Busir	ness/Ind	lustry
within 72 hours after death with the Maryland one. then "natural", or Items 23e or 28e-1 show the Phydical Ever inet mast be inclified at	mpi	Elementary/Secondary (0-12)	College	(1-4or 5+)	life. E	OO NOT use retired	d)			7	- f	and	()
Hygie ther		17 Father's Name (First, Middle, L	Last)		<u> </u>	ートカマ	18. Mothe	r's Name	(First, Middle	Maiden	Sumame		
id be ental ked o	To Be	Dontrail	Res	don				Ko		Sin			
shou ind M mar umat	-	19a. Informant's Name/Relationsh	nip (Type, Print)	aca r	19b. Mailin	g Address (Street	and Numbe	r or Rural				ate, Zip	Code)
ges 1 and 2 should be lied within 72 hours atter death with the Maryla it of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or Items 23a or 28e-f show or other treumatic event. The Medical Examinet must be notified at		Kelly SI	ACK (moth	2	001 2	Soker	. 8	A. 7	3-14	", more	m	7 3191
of He		20a. Method of Disposition	2 Domoval fro		emetery, crem	sition (Name of natory or other place	ce)	Da	ite	20c. Lo	cation - Cit	ty or Tov	wn, State
		1 ☐ Burial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (Sp	becify)	m State Met	ro Cre	matory		/17/0	05	Ba1t	timor	e, M	id.
permit. Pa Departmer Importent eny injury once.		21. Signature of Funeral Service L	_icense#		22	. Name and Addre	ss of Facility	,		D. 1.		3.00	01017
20 = 0 a	100	Ionothon I	Tobaca ((DTD)	774	• 11 1 • • •				rant:	lmore.	, MU). Z1Z1/
		Jonathan H		(per DVR)	Ph	ullips F	.н. 1	721–2			oe St		
		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications tha	at caused the death	Ph	ullips F	.н. 1	721–2			imore be St		Approximate Interval Between
		23a. Part1. Enter the disease, or	complications tha only one cause or a.	at caused the death	Ph. Do not ente	ullips F	.н. 1	721–2			imore be St		Approximate Interval Between
/Medical		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	complications tha only one cause or a.	at caused the death	Ph. Do not ente	ullips F	.н. 1	721–2			imore se St		Approximate Interval Between
/Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a	at caused the death	Ph. Do not enter	ullips F	.н. 1	721–2			imore be St		Approximate Interval Between
/Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List of limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a	t caused the death n each line.	Ph. Do not enter	ullips F	.н. 1	721–2			imore be St		Approximate Interval Between
/Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a	t caused the death n each line.	Ph. Do not enter userce of):	ullips F	.н. 1	721–2			imore be St		Approximate Interval Between
/Medical Examiner	Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a	at caused the death n each line.	Ph. Do not enter userce of):	ullips F	.н. 1	721–2			imore be St		Approximate Interval Between
/Medical Examiner	Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	at caused the death neach line. It of or as a consequence of o for a fo	Ph. Do not enter service of):	ullips F	.н. 1	721–2		arrest,			Approximate Interval Between Onset and Death
/Medical Examiner	Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	a	it caused the death neach line. It caused the death neach line. It could be consequent to (or as a consequent to (or as a consequent to or as a conseque	n. Do not enter uence of): uence of): uence of):	aillips F or the mode of dyin	P.H. 1	721–2		arrest,	imore oe St	of deliver	Approximate Interval Between Onset and Death
/Medical Examiner	Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	a	it caused the death neach line. It caused the death neach line. It consequence to (or as a consequence of or as a consequence of pregnant at time of death and the consequence of pregnant at time of death and the consequence of pregnant at time of death and the consequence of pregnant at time of death and the consequence of pregnant at time of death and the consequence of pregnant at time of death and the consequence of pregnant at time of death and the consequence of pregnant at time of death and the consequence of pregnant at time of death and the consequence of the consequ	n. Do not enter uence of): uence of): uence of):	nillips F er the mode of dyin	P.H. 1	721–2		arrest,	23d. Date o	of deliver	Approximate Interval Between Onset and Death
/Medical Examiner	Physician/Medical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	a. Due t b. Due t c. Due t d. 23c. If yes, c 1 Live 4 Pre 9 Uni	to caused the death neach line. To (or as a consequence of or as a consequence of pregname points at time of descriptions).	n. Do not enter uence of): uence of): uence of):	Ectopic pregnancy	P.H. 1	721–2	respiratory a	arrest,	23d. Date o Month	of deliver	Approximate Interval Between Onset and Death Onset and Peath y Day Year
/Medical Examiner	by Physician/Medical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due t b. Due t c. Due t d. 23c. If yes, c 1 Live 4 Pre 9 Uni	to caused the death neach line. To (or as a consequence of or as a consequence of pregname points at time of descriptions).	n. Do not enter uence of): uence of): uence of):	Ectopic pregnancy	P.H. 1	721–2	respiratory a	tobacco u	23d. Date o Month se contribu	of deliver	Approximate Interval Between Onset and Death
/Medical Examiner	by Physician/Medical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due t b. Due t c. Due t d. 23c. If yes, c 1 Live 4 Pre 9 Uni	to caused the death neach line. To (or as a consequence of or as a consequence of pregname points at time of descriptions).	n. Do not enter uence of): uence of): uence of):	Ectopic pregnancy	P.H. 1	721–2	23e. Did 1	tobacco u Yes 2	23d. Date o Month se contribu No 3[of deliver	Approximate Interval Between Onset and Death Death Onset and D
/Medical Examiner	by Physician/Medical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due t b. Due t c. Due t d. 23c. If yes, c 1 Live 4 Pre 9 Uni	to caused the death neach line. To (or as a consequence of or as a consequence of pregname points at time of descriptions).	n. Do not enter uence of): uence of): uence of):	Ectopic pregnancy	P.H. 1	721–2	23e. Did 1	tobacco u Yes 2	23d. Date o Month se contribu No 3[24b. Wer prio deai	of deliver	Approximate Interval Between Onset and Death Death Onset and D
/Medical Examiner	e Completed by Physician/Medical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due t b. Due t c. Due t d. 23c. If yes, c 1 Live 4 Pre 9 Uni	to caused the death neach line. To (or as a consequence of or as a consequence of pregname points at time of descriptions).	n. Do not enter uence of): uence of): uence of):	Ectopic pregnancy	P.H. 1	721-2	23e. Did	tobacco u Yes 2	23d. Date o Month se contribu No 3[24b. Wer prio deai	of deliver	Approximate Interval Between Onset and Death Death Onset and D
Examiner	Completed by Physician/Medical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due t b. Due t c. Due t d. 23c. If yes, c 1 Live 4 Pre 9 Uni	to caused the death neach line. To (or as a consequence of or as a consequence of pregnance bottom 2 Fetal ignant at time of death but not resulting the consequence of the consequen	n. Do not enter uence of): uence of): uence of):	Ectopic pregnancy Other (specify)	ren in Part I. 26. Place er: 4 \subseteq Nur	721-2	23e. Did 1 1 = 24a. Was auto perfe 1 = Yes Check on	tobacco u Yes 2 is an psy psy 2 Xoone	23d. Date o Month se contribu	of deliver [Proba re autop re to com th? Yes 2	Approximate Interval Between Onset and Death Death Onset and D
/Medical Examiner	To Be Completed by Physician/Medical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due t b. Due t c. Due t d. 23c. If yes, c 1 Live 4 Pre 9 Uni ns contributing to	at caused the death neach line. To (or as a consequence of or as a consequence of pregnar a birth 2 Fetal grant at time of death but not result of death but not result.	ph. Do not enter uence of): uence of): uence of): uence of): uence of): uence of): uence of): uence of):	Ectopic pregnancy Other (specify)	ren in Part I. 26. Place er: 4□ Nur yk?	721-2 cardiac or	23e. Did	tobacco u Yes 2 is an propried? 2 Some	23d. Date o Month se contribu No 3[24b. Were prio dea 1	of deliver [Proba re autop re to com th? Yes 2	Approximate Interval Between Onset and Death Death Onset and D
ding Physicien: The law requires that the death certificate be executed by the attending physician and line and funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due t b. Due t c. Due t d. 23c. If yes, c 1 Live 4 Pre 9 Uni ns contributing to	it caused the death neach line. It caused the death neach line. It caused the death neach line. It caused the death line. It caused the death line. It caused the death line. It consequence of pregnance of or as a consequence of pregnance of pregnant at time of death line of death line of death line of death line of death line of death line of death line of death line of death line of death line of	Ph. Do not enter Lence of):	Ectopic pregnancy Other (specify) 28c. Injun Month	ren in Part I. 26. Place er: 4 \subseteq Nur y at	of Death Sing Home	23e. Did 1 24a. Was auto	tobacco u Yes 2 s an psy 2 2 xone idence 6 how injury	23d. Date o Month se contribu 24b. Wer prio deai	of deliver [Description of the companies of the compan	Approximate Interval Between Onset and Death Death Onset and D
ding Physicien: The law requires that the death certificate be executed by the attenting physician and the property of the pro	To Be Completed by Physician/Medical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due t b. Due t c. Due t d. 23c. If yes, c 1 Live 4 Pre 9 Uni ns contributing to	to caused the death neach line. To (or as a consequence of or as a consequence of pregnance bottom 2 Fetal ignant at time of death but not resulting the consequence of the consequen	Ph. Do not enter Lence of):	Ectopic pregnancy Other (specify) 28c. Injun Month	ren in Part I. 26. Place er: 4□ Nur yk?	of Death Sing Home	23e. Did 1 24a. Was auto	tobacco u Yes 2 an psy promed? 2 dence 6 how injury	23d. Date o Month Se contribu 24b. Were prio dea 1 6 Other (y occurred	of deliver [Description of the companies of the compan	Approximate Interval Between Onset and Death Death Onset and D
ding Physicien: The law requires that the death certificate be executed to the later this certificate has been signed by the attending physician and the property of the later this certificate has been signed by the attending physician and the primary funeral director, page 2 should be detached for use as the burial-transit and positive the later than the later tha	Certification; To Be Completed by Physician/Medical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 — Yes 2 — No 9 — Unknown Part II. Other significant conditions. 25. Was case referred to medical examiner? 1 — Yes 2 — No 27. Manner of Death — Salvard Salva	a. Due t b. Due t c. Due t d. 23c. If yes, c 1 Live 4 Pre 9 Uni ns contributing to Hospital: 15 28a. Dat (Mc ation oot be ned 28e. Pla	to caused the death neach line. To (or as a consequence of or as a consequence of pregnance brith 2 Fetal agrant at time of de known or death but not resulted of Injury onth, Day Year) ce of Injury - At holding, etc. (Specify	ph. Do not enter uence of):	Ectopic pregnancy Other (specify) and DOA 28c, Injun Wort M 1 pet, factory, office	ren in Part I. 26. Place er: 4 \(\text{Nur} \) yat k? Yes 2 \(\text{Nur} \)	of Death sing Hom	23e. Did 1 24a. Was auto perfection of City or To	tobacco u Yes 2 san psy ormed? 2 Sho one Idence 6 how injury	23d. Date o Month Se contribu 24b. Wer prio dea 1 □ 5 □ Other (y occurred	of deliver If If the to the proba re autoprito comits the proba (Specify) or Rural	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset
ding Physicien: The law requires that the death certificate be executed by the attenting physician and the property of the pro	Certification; To Be Completed by Physician/Medical Examiner	23a. Part 1. Enter the disease, or shock, or heart failure. List of limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Dther significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Investigation	a. Due t b. Due t c. Due t d. 23c. If yes, c 1 Live 4 Pre 9 Uni ns contributing to Hospital: 18 28a. Dat (Mc ation of be ned 28e. Pla buil	it caused the death neach line. It caused the death neach line. It caused the death neach line. It caused the death line. It caused the death line. It caused the death line. It consequence of pregnance of or as a consequence of pregnance of pregnant at time of death line of death line of death line of death line of death line of death line of death line of death line of death line of death line of	Ph. Do not enter Lence of):	Ectopic pregnancy Other (specify) 28c. Injun M 1 28c. Injun Set, factory, office	ren in Part I. 26. Place er: 4 □ Nur y at k? Yes 2 □ N	of Death sing Home	23e. Did 1 1 24a. Was auto 1 Yes Check on e 5 Resi 8d. Describe	tobacco u Yes 2 an an psy 2 Section one Idence 6 how injury (Street analysis)	23d. Date o Month se contribu 24b. Wer prio deal 1	of deliver [Proba Proba re autop rito com th? Yes 2 (Specify) or Rural	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset Ons
ng Physicien: The law requires that the death certificate be executed to the restriction and the restriction page 2 should be detached for use as the burial-transit of the restriction.	To Be Completed by Physician/Medical Examiner	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due t b. Due t c. Due t d. 23c. If yes, c 1 Live 4 Pre 9 Uni ns contributing to Hospital: 18 28a. Dat (Mc ation of be ned 28e. Pla buil	at caused the death neach line. It caused the death neach line. It consequence to (or as a consequence of pregnance) birth 2 Fetal gnant at time of death but not result to (Injury onth, Day Year) It colding, etc. (Specify the best of my know be basis of examinat	Ph. Do not enter Lence of):	Ectopic pregnancy Other (specify) 28c. Injun M 1 28c. Injun Set, factory, office	ren in Part I. 26. Place er: 4 □ Nur yat Yes 2 □ N	of Death sing Home	23e. Did 1 1 24a. Was auto 1 Yes Check on e 5 Resi 8d. Describe	tobacco u Yes 2 s an psy ormed? 2 Street and wm, State) cause(s) date and	23d. Date o Month se contribu 24b. Wer prio deal 1	of deliver Ute to the Proba Proba re autoport to com th? Yes 2 (Specify) or Rural er as sta	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Onset
ding Physicien: The law requires that the death certificate be executed by the attending physician and line and funeral director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical Examiner	23a. Part 1. Enter the disease, or shock, or heart failure. List of limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due t b. Due t c. Due t d. 23c. If yes, c 1 Live 4 Pre 9 Uni ns contributing to Hospital: 18 28a. Dat (Mc ation of be ned 28e. Pla buil	at caused the death neach line. It caused the death neach line. It consequence to (or as a consequence of pregnance) birth 2 Fetal gnant at time of death but not result to (Injury onth, Day Year) It colding, etc. (Specify the best of my know be basis of examinat	Ph. Do not enter Lence of):	Ectopic pregnancy Other (specify) 28c. Injun Wort M 1 2	ren in Part I. 26. Place er: 4 □ Nur yat Yes 2 □ N	of Death sing Home	23e. Did 1 1 24a. Was auto 1 Yes Check on e 5 Resi 8d. Describe	tobacco u Yes 2 s an psy ormed? 2 Street and wm, State) cause(s) date and	23d. Date o Month se contribu 24b. Wer prio dea 1 1 6 Other (y occurred	of deliver Ute to the Proba Proba re autoport to com th? Yes 2 (Specify) or Rural er as sta	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Onset
ding Physicien: The law requires that the death certificate be executed by the attending physician and line and funeral director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical Examiner	23a. Part 1. Enter the disease, or shock, or heart failure. List of limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to be and many one 28e. Pla building Physician: To the sand many one 28e. Pla buildings on the and many one 28e. Pla buildings on the and many of the sa	at caused the death neach line. It caused the death neach line. It consequence to (or as a consequence of or as a consequence of pregnance) but the point of the consequence of the co	ph. Do not enter uence of):	Ectopic pregnancy Other (specify) 28c. Injun M 1 28c. Injun Wor M 28c. Injun Wor M 29c. License	ren in Part I. 26. Place er: 4 □ Nur yat Yes 2 □ N	of Death sing Home	23e. Did 1 1 24a. Was auto 1 Yes Check on e 5 Resi 8d. Describe	tobacco u Yes 2 s an psy ormed? 2 Street and wm, State) cause(s) date and	23d. Date o Month se contribu 24b. Wer prio dea 1 1 6 Other (y occurred	of deliver Ute to the Proba Proba re autoport to com th? Yes 2 (Specify) or Rural er as sta	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset Indiana

amend 25,27 per Dr. g853ease 3/9606 PKBHin Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2005 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month & **Physician** 248 Baby Girl Albarado /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hopkins Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 □ M 2 🙀 F Yrs. Director none Aug 7, Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 27 is marked other then "natural", or items 23s or 28e-f show troumstic event, the Medical Examinar must be notified at MD Baltimore Director Windsor Mill 1 ☐ Yes 2√2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene important: If Item 27 is marked other then "natural; or items 23a any jnjury or other treumatic event, It, a Wedical Exampler means once. 104 Village of Pine Mill #3A Funeral 21244USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A' Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Travis Allyne Gail Albarado 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johns Hopkins Hospital 600 Wolfe Street Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 X Other (Specify) 21. S malus of Funeral Service Licensee Ronald S 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MĎ 21201 23a. Part. Enter the disease, or complications that caused the shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Gause (Final disease or condition resulting in death) xtreme **Physician** /Medical Due to (or as a consequence of): Examiner U Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the a 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has l director, page 2 s autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ↑ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After Natural Accident 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No **Director:** 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a ths Hospitei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 (am 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) street 2006 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0

DHMH 17 Rev 1/2001

Registrar

	an	1. Decedent's Name <i>(First, Middle, Last)</i> Joseph Evans	of Marylan r INF G8 6a&b,17,1 s					2. Date of Deat Decembe	h	2005	3. Time of Death 2:48a.
ledic amin		4a. Facility Name (If not institution, give street and	nu <i>mber)</i>		4b. City, To	own, or Location of			1	nty of Death	
		5514 Midwood Avenue				cimore C					
eral tor		5. Social Security Number 6. Sex 1 X 2 1 4 - 59 - 3512	7. Age (In yrs. 56	iast birthday Yrs.		Year If Under: Days Hours	Min.	8. Date of Birth (Month, Day, 9/23/19	Year)	Сош	
		Usual Residence of Decedent	10.00		-1			J/25/17			th Caroli
9 20	5	10a. State 10b. County Maryland		timor							1 (TYYes 2 □
OTHER TREUTHAND SVENIL METERS EXPONENT THE TREET OF THE PROPERTY OF	Funeral Director	10e. Street and Number	Dai	LLINOL	10f. Zip Ci	code		1	0g. Citizen	of What Cour	ntry?
100	alD	5514 Midwood Avenue			212	218			USA		
0010	nue	Armed	Decedent Ever in U 1 Forces?	.S. 13	B. Was Deceden If Yes, specify	nt of Hispanic Ori y Cuban, Mexican	gin? (Spec i, Puerto R	ofy Yes or No- lican, etc.)		Race - Americ Black, White,	
	Ď	If Yes.	es 2 XNo , Give or Dates:		1 ☐ Yes 2 💆	X No Specify:			Spe	city: Bla	ack
1000	Completed	15. Decedent's Education (Specify only highest grade complete	ed)	16a. Dec	edent's Usual (Occupation done during most	t of working	a	16b. Kind of	Business/In	dustry
BW B	mp		ge (1-4or 5+)	/ife.	. DO NOT use	retired)				2020	
, L	Be Co	17. Father's Name (First, Middle, Last)		Di	isabled	18. Mothe	rs Name	(First, Middle, Mae Cha	Maiden Sum	none	
	To B	Robert Evans Doborob	Franc / an			1 1	PODO:	Fh H	vanc		
		19a. Informant's Name/Relationship (1908 Print)	Evans/spo	1111	19 ^d Hari	ford Rd	Balt	imore,	1dy 212	Atate, Zip	Code)
		20a. Method of Disposition		TII	o Giene position (Name	agie nos	id Ba	arthior	e, mai	y Land on - City or To	21239
eny injury or other		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 1 ☐ Donation 5 ☐ Other (Specify)		emetery, cr	ematory or othe	er place)			LVO. EUGGIIO	Only or re	, otato
in di		21. Signature of Funeral Solvice Licensee Ronal d S. Wade	Birector	- :	23 Name and	Address of Facility	Koard	655 W.	Ralt	imore	Street
Suc Suc		man 1/1C	Me		Baltimo	-			Dare	Imole	DELCCE
ian cal	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions		on each line.	clero	nter the mode o	of dying, such as	cardiac or	respiratory arre		sease	Approximate Interval Between Onset and Death
cal ner	cai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	therasi	clero juence of):	nter the mode o	of dying, such as	cardiac or	respiratory arre		SEASE	Interval Between
cal ner	cai	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	to (or as a consequence to (or as a consequence)	uence of): uence of): uence of):	nter the mode o	of dying, such as Ardid	cardiac or	respiratory arre	23d. [Date of deliver	Interval Betweer Onset and Death
cal ner	Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No. 4	outcome of pregnat eignant at time of dinknown	uence of): uence of): uence of): uence of): ancy il death 3 leath 5	B Ectopic preg	of dying, such as ArdiD gnancy	cardiac or	respiratory arre	23d. I	Date of delive	Onset and Deat Onset and Deat Onset and Deat Year
cal ner	by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	outcome of pregnat eignant at time of dinknown	uence of): uence of): uence of): uence of): ancy il death 3 leath 5	B Ectopic preg	of dying, such as ArdiD gnancy	cardiac or	respiratory arre	23d. I	Date of delive	Onset and Deat Onset and Deat Onset and Deat Onset and Deat
cal ner	by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	outcome of pregnat eignant at time of dinknown	uence of): uence of): uence of): uence of): ancy il death 3 leath 5	B Ectopic preg	of dying, such as ArdiD gnancy	cardiac or	23e. Did tot	23d. I	Date of delivered Month ontribute to the state of the sta	onset and Deate Onset and Deate Onset and Deate Onset and Deate Onset and Deate Onset and Deate Onset and Deate Onset and Deate Onset Onse
cal ner	by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	outcome of pregnat eignant at time of dinknown	uence of): uence of): uence of): uence of): ancy il death 3 leath 5	B Ectopic preg	of dying, such as ArdiD gnancy	cardiac or	23e. Did tot 1 Ye 24a. Was al autops perform	23d. [Date of delivered Month ontribute to the state of the sta	onset and Deate
cal ner	Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	on each line. Herbschoto (or as a consequence to (or as a consequence consequence) outcome of pregnave birth 2 Feta regnant at time of disknown	uence of): (uence of): (uence of): ancy (I death 3 leath 5	B Ectopic pregion Other (special underlying cause	gnancy use given in Part I.	cardiac or	23e. Did tot 1 Ye 24a. Was a autops perform 1 Yes 2 (Check only on	23d. I	Date of delivered Month ontribute to the autoprior to codeath?	onset and Death onset
cal ner	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	outcome of pregnate degrant at time of disknown	juence of): juence of): juence of): ancy al death 3 leath 5 juence of items in the	B Ectopic pregic Other (special underlying cause	gnancy sity) 26. Place Other: 4 Nu	of Death	23e. Did tot 1 Yes 24a. Was a autops perforn 1 Yes 2 (Check only on	23d. I	Date of deliver Month Ontribute to the Service autoprior to co-death? 1 Yes	Onset and Deate on Onset on On
cal ner	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	on each line. Herbschoto (or as a consequence to (or as a consequence consequence) outcome of pregnave birth 2 Feta regnant at time of disknown	uence of): uence of): uence of): ancy I death 3 leath 5 ulting in the	B Ectopic pregic Other (special underlying cause	gnancy use given in Part I.	of Death	23e. Did tot 1 Ye 24a. Was a autops perform 1 Yes 2 (Check only on	23d. I	Date of deliver Month Ontribute to the Service autoprior to co-death? 1 Yes	Onset and Death Onset and Death Pry Day Year The cause of death pably 4 Winkin Pry Tindings avait mpletion of cause 2 No
cal ner	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	outcome of pregnate degrant at time of disknown	uence of): uence of): uence of): ancy I death 3 leath 5 ulting in the	ent 3 DOA of M	gnancy grancy 26. Place Other: 4 Nu c. Injury at Work? 1 Yes 2	of Death rsing Hom	23e. Did tot 1 Ye 24a. Was a autops perform 1 Yes 2 (Check only on	23d. I	Date of delivered Month Dontribute to the autoprior to condeath? 1 Yes Other (Specifications)	Onset and Death Onset and Death Pry Day Year The cause of death pably 4 Winking psy findings avail- mpletion of cause 2 No
cal ner	Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	on each line. Hero Scale to (or as a consequence of or as a consequence of or as a consequence of the conse	uence of): uence	ent 3 DOA of 28c. M street, factory, o	gnancy grancy Death rsing Home	23e. Did tot 1 Ye 24a. Was al autops perform 1 Yes 2 (Check only onle 5 Reside 3d. Describe ho	23d. I	Date of deliver Month Dontribute to the autoprior to condeath? 1 Yes Other (Specificurred	onset and Death onset	
ector, page x should be datached for use as the bunar-transit	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	outcome of pregna ve birth 2 Feta egnant at time of dinknown Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpa	uence of): uence	ent 3 DOA of 28c. M street, factory, of alth occurred at investigation, in	gnancy grancy Death rsing Home	23e. Did tot 1 Yes 24a. Was a autops perform 1 Yes 2 (Check only on e 5 Reside 8d. Describe ho	23d. I	Date of deliver Month Dontribute to the autoprior to condeath? 1 Yes Other (Specificurred	onset and Death onset	
cal ner	Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to the past 12 months? 1 Yes 2 No 9 Unknown 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Yes 2 No Yes 2 No Yes 2 No Yes 2 No Yes 2 No Yes 2 No Yes 2 No Yes 2 No Yes 2 No Yes 2 No Yes 2	outcome of pregnave birth 2 Feta regnant at time of dinknown of death but not resulting at the best of my known anner stated. Medical I	uence of): uence	ent 3 DOA of Astreet, factory, of ath occurred at investigation, in 29c. Lener	gnancy gnancy grancy Death rsing Home	23e. Did tot 1 Ye 24a. Was a autops perforn 1 Yes 2 (Check only on e 5 Reside 3d. Describe ho ad the time, da at the time, da	23d. I	Date of deliver Month ontribute to the state of the state	onset and Death onset and Death onset and Death onset and Death onset and Death onset and Death onset of death	

DHMH 17 Rev 1/2001

		1. Decedent's Name (First, Midd		State of 23a,							2. Date of De	ath			- 43887 3. Time of Death
sician	n		alla								Month Decembe	Da	-	Year 205	10:10 a
edical miner		4a. Facility Name (If not institution			ımber)		4b. City,	Town, or	Location of		Decembe		. County		1 10.10 a
miles		Charlestown Re	tire	ement (Center		Cat	cons	ville				Balt	timoı	re
al		5. Social Security Number	6. Sex		7. Age (In yrs	. last birthday)	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Bir (Month, Da	rth ay, Year)		9. Birthr	place (State or Foreig
or		215-16-0084		M 2√xF	82	Yrs.					July 12		923		zland
	1-	Usual Residence of Decedent 10a. State 10b. County	v		10c. C	ity, Town or Lo	ocation							1	Od. Inside City Limits
2	_	Maryland Balti	more		C	atonsvi	110								1 ☐ Yes 2 🔀 No
0	3	10e. Street and Number	HOLE	•		a consvi	10f. Zip	Code	• • • •			10g. Cit	izen of W	Vhat Cour	ntry?
To Be Completed by Funeral Director	5	715 Maiden C	hoic	e Lane	9		212					Ţ	J.S.A	A.	•
Funeral Directo	<u>e</u>	11. Marital Status		12. Was Dec	edent Ever in l	J.S. 13.	Was Deced	ent of Hi	spanic Orig	gin? (Spe	ecify Yes or No	o- T			can Indian,
F	2	1 Never Married 2 Ma	rried	Armed F	2 🔀 No					, Puerto	Rican, etc.)			k, White.	etc.
2	2	3X Widowed 4 ☐ Divorce	d	If Yes, Gi Year or D	ive Dates:		1 Yes 2	2 X) No	Specify:				Specify	Wh	nite
Completed	2	15. Decede (Specify only highe)	16a. Dece	dent's Usua kind of wor	I Occupa	ation Jurina most	of worki	na	16b. K	ind of Bu	siness/In	dustry
alau	<u> </u>	Elementary/Secondary (0-12)	Ť	College (life.	DO NOT us	e retired							
٥	5	12				Homema	aker_				(m)		Hon		
8	מ	17. Father's Name (First, Middle	_								(First, Middle	, Maiden	Sumam	Θ)	
٩	2	Archie Elsroad	_								Grace				
	1	19a. Informant's Name/Relation				1	•				I Route Numb				-
Ŧ		Cassandra Junk	- Da	ugnter					ı ka,		stersto				
1	1	20a. Method of Disposition tx□ Burial 2 □ Cremation	3 □R	emoval from		Place of Dispo cemetery, crea	matory or ot	ne or ther place	e)	L	Jate	20c. Lo	ocation -	City or 10	own, State
		4 Donation 5 Other (Specity)			edowrido	e Memor	rial I	Park 12	2/15	/2005	Elkr	idge	e. Ma	ryland
e e e e e e e e e e e e e e e e e e e		21. Signature of Funeral Service	License	90		22	2. Name and Garv	d Addres	s of Facility	y an Fi	uneral	Home	at	MMP.	TNC
ā		1 / Ahr	_			î.	7250	Wash	inate	n R	lvd., E	lkri	dao	MD'	21075
		23a. Parti. Enter the disease. C				* Da							age,		21075
in		23a. Part 1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition	or complicationly on	cations that ne cause on	1	Acute R	er the mode	e of dying Insu	g, such as	cardiac c	r respirator a		age,		Approximate Interval Between Onset and Death
П		Immediate Cause (Final	or compliationly on		1	Renal	er the mode	e of dying Insu	g, such as	cardiac c	r respirator a		ude,		Approximate Interval Between
l r		Immediate Cause (Final disease or condition resulting in death)	or compliationly on	Due to	- Acuto (or as a conse	Renal quence of):	er the mode	e of dying Insu	g, such as o	cardiac o	or respirator a	rrest,			Approximate Interval Between
al er	<u>.</u>	Immediate Cause (Final disease or condition resulting in death)	٢	Due to	Acuto	Renal quence of):	er the mode	e of dying Insu	g, such as o	cardiac o	or respirator a	rrest,			Approximate Interval Between
il F	<u>.</u>	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury that initiated events	٢	Due to	Acute (or as a conse	quence of):	er the mode	e of dying Insu	g, such as o	cardiac o	or respirator a	rrest,			Approximate Interval Between
Examiner	Evalillie	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	A B B C B C B C C C C	Due to	- Acuto (or as a conse	quence of):	er the mode	e of dying Insu	g, such as o	cardiac o	or respirator a	rrest,			Approximate Interval Between
Examiner	Evalillie	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury that initiated events	A B B C B C B C C C C	Due to	Acute (or as a conse	quence of):	er the mode	e of dying Insu	g, such as o	cardiac o	r respirator a	rrest,			Approximate Interval Between
Examiner	Evalillie	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to Due to	Acute (or as a conse	quence of): quence of):	er the mode	e of dying Insu	g, such as a	cardiac o	or respirator a	rrest,	XAMINER		Approximate Interval Between Onset and Death
Examiner	Evalillie	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Exist Uncertain Cause (Disease or injury that initiated events resulting in death) Last		Due to Due to Due to Jue to Due to	Acute (or as a conse	quence of): quence of): quence of):	ter the mode Renal Failt	e of dying Insu	g, such as a	cardiac o	or respirator a	rrest,	XAMINER	e of delive	Approximate Interval Between Onset and Death
Examiner	Evalillie	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Early Uncertaing Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant		Due to Due to Due to Jue to Due to	Acute (or as a consection of pregration of pregration and at time of	quence of): quence of): quence of):	ter the mode enal Fails	e of dying Insu	g, such as a	cardiac o	or respirator a	rrest,	XAMINER 23d. Date	e of delive	Approximate Interval Between Onset and Death
Physician/Medical Examiner	riigsiciail/infedical Challinner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Exist uncertain Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		Due to Due to Due to Due to	(or as a consection of pregretation of the control	quence of): quence of): quence of): quence of):	ter the mode enal Fail: Ectopic pre	e of dying Insu	g, such as a suffici	cardiac of Lency	or respirator a	EDICAL E	XAMINER 23d. Date Mon	e of delive	Approximate Interval Between Onset and Death
by Physician/Medical Examiner	Dy Filysicial Medical Examinist	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. First Uncertainty Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a b c c d d	Due to Due to Due to Due to	(or as a consection of pregretation of the control	quence of): quence of): quence of): quence of):	ter the mode enal Fail: Ectopic pre	e of dying Insu	g, such as a suffici	cardiac of Lency	or respirator a	obacco u	XAMINER 23d. Date Mon	e of delive	Approximate Interval Between Onset and Death Bry Day Year The cause of death?
by Physician/Medical Examiner	Dy Filysicial Medical Examinist	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Exist uncertain Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a b c c d d	Due to Due to Due to Due to	(or as a consection of pregretation of the control	quence of): quence of): quence of): quence of):	ter the mode enal Fail: Ectopic pre	e of dying Insu	g, such as a suffici	cardiac of Lency	PROVED BY M	obacco u	23d. Date Mon	e of deliventh	Approximate Interval Between Onset and Death Bry Day Year De cause of death? Bry All Dunknown
by Physician/Medical Examiner	Dy Filysicial Medical Examinist	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. First Uncertainty Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a b c c d d	Due to Due to Due to Due to	(or as a consection of pregretation of the control	quence of): quence of): quence of): quence of):	ter the mode enal Fail: Ectopic pre	e of dying Insu	g, such as a suffici	cardiac of Lency	23e. Did t	obacco u	23d. Date Mon use contri	e of deliventh ibute to th	Approximate Interval Between Onset and Death Bry Day Year De cause of death? Bry All Dunknown
by Physician/Medical Examiner	Dy Filysicial Medical Examinist	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. First Uncertainty Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a b c c d d	Due to Due to Due to Due to	(or as a consection of pregretation of the control	quence of): quence of): quence of): quence of):	ter the mode enal Fail: Ectopic pre	e of dying Insu	g, such as a suffici	cardiac of Lency	23e. Did t	obacco u	23d. Date Mon use contri	e of deliventh ibute to th Prob Vere autorior to coreath?	Approximate Interval Between Onset and Death Bry Day Year The cause of death? The cause of death ably 4 Unknown psy findings available
Physician/Medical Examiner	e completed by rugsicial medical manning	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. First Uncertainty Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a b c c d d	Due to Due to Due to July to Due to July to	(or as a consection of pregretation of the control	quence of): quence of): quence of): quence of):	ter the mode enal Fail: Ectopic pre	e of dying Insu UTO egnancy ecity) ause give	g, such as a sufficial of the sum	cardiac c	23e. Did t	obacco u Yes 2 an an an an an an an an an an an an an	23d. Date Mon use contri	e of deliventh ibute to the state of the st	Approximate Interval Between Onset and Death Bry Day Year the cause of death? ably 4 Unknown psy findings available impletion of cause of
e Completed by Physician/Medical Examiner	to be completed by rugsicial medical examinate	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. End the principle Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a b c c d d	Due to Due to Due to Due to July et a control of the control o	(or as a consection of pregretation of pregret	quence of): quence of): quence of): quence of): quence of): ancy al death 3 [death 5 [sulting in the u	er the mode enal Fails	e of dying Insu UPO egnancy ecity) ause give	g, such as a sufficial of the sufficial of the sufficial of the sufficient of the su	cardiac coi.ency	23e. Did t 24a. Was autor period 27 c (Check only come 5 session of the company)	obacco u Yes 2 an Dsy ormed? 2 No	23d. Date Mon use contri 24b. W	e of deliventh ibute to the state of the st	Approximate Interval Between Onset and Death Bry Day Year De cause of death? Bry A Dunknown Psy findings available pletion of cause of
To Be Completed by Physician/Medical Examiner	to be completed by rugsicial medical examination	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. It is the property of the p	ions con	Due to Due to Due to Due to July et a control of the control o	Acute (or as a consection of pregration of p	quence of): quence of): quence of): quence of): ancy al death 3 [death 5 [er the mode enal Fails Fails Cenal Fails Cenal Fails Control	e of dying Insu UTO egnancy ecify) ause give	g, such as a sufficial of the sufficial of the sufficial of the sufficient of the su	cardiac of Lency cardiac of Lency of Death	23e. Did t 24a. Was autor perior 1 Yes	obacco u Yes 2 an Dsy ormed? 2 No	23d. Date Mon use contri 24b. W	e of deliventh ibute to the state of the st	Approximate Interval Between Onset and Death Bry Day Year De cause of death? Bry A Dunknown Description of cause of
To Be Completed by Physician/Medical Examiner	to be completed by rugsicial medical examination	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. First Uncertainty Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condit. Preumonia 25. Was case referred to medical examiner? 1 Yes 2 No 9 Vision	ions con	Due to Due to Due to Due to Comparison of the comparison of th	Acute (or as a consection of pregration of p	quence of): quenc	er the mode email Failt Ectopic pro- Other (specific product) Indexlying car at 3 DO f 21	e of dying Insu UPPO egnancy ecify) ause give	g, such as a sufficial of the sufficial of the sufficial of the sufficient of the su	cardiac of Lency CATION A of Death	23e. Did t 24a. Was autopring period 27 Check only come 5 esice	obacco u Yes 2 an oby 2 No one) dence how injur	23d. Date Monuse contribution 24b. William 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	e of deliventh ibute to th 3 Prob Vere autorior to core eath? Q Yes or (Specif)	Approximate Interval Between Onset and Death Party Day Year The cause of death? The cause of death? The cause of death? The cause of death? The cause of death?
To Be Completed by Physician/Medical Examiner	to be completed by rugsicial medical examination	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter the territory cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ions con	Due to Due to Due to Due to Output Due to Output Due to Output Due to Due to Due to Due to Due to	(or as a consection of pregretation of pregret	quence of): quenc	er the mode email Failt Ectopic pro- Other (specific product) Indexlying car at 3 DO f 21	e of dying Insu UPPO egnancy ecify) ause give	g, such as a sufficial of the sufficial of the sufficial of the sufficient of the su	cardiac of Lency CATION A of Death	23e. Did t 24a. Was autopring period 27 Check only come 5 esice	obacco u Yes 2 an DSY Omed? 2 No Ome) dence how injur	23d. Date Monuse contribution 24b. William 1	e of deliventh ibute to th 3 Prob Vere autorior to core eath? Q Yes or (Specif)	Approximate Interval Between Onset and Death Bry Day Year De cause of death? Bry A Dunknown Description of cause of
Certification: To Be Completed by Physician/Medical Examiner	del micanoni, 10 de comprete duy ruyalciai miedicai Examine	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Each underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ions conditions all the mined	Due to Due to Due to Due to July et a line of the control of t	(or as a consection of pregretation of pregret	quence of): quenc	Ectopic prediction of the state of the model of the state	egnancy ecity) ause give	g, such as a sufficial service of the sufficial service of the sufficient of the suf	cardiac of i.ency	23e. Did to 1 24a. Was autoperforme 5 esia (Check only of City or Town 28f. Location (Scity or Town 28f	obacco u Yes 2 an posy med? 2 No one) dence how injur	23d. Date Monuse contribute 24b. W 1 1 6 Other y occurred Number	e of deliventh sibute to the	Approximate Interval Between Onset and Death Bry Day Year De cause of death? Bry A Dunknown Psy findings available in pletion of cause of cause of cause of cause of cause of the cause
Certification: To Be Completed by Physician/Medical Examiner	del micanoni, 10 de comprete duy ruyalciai miedicai Examine	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Early uncertainty Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condit Precumonia 25. Was case referred to medical examiner? 1 Xes 2 No 9 Unknown 27. Manger of Death Natural S Pendi	ions con a H	Due to Due to Due to Due to Due to Comparison of the comparis	(or as a consection of pregretation of pregret	quence of): quenc	Dectopic pro-	egnancy ecify)ause give at the time	g, such as a sufficial representation of the sufficial representation of the sufficient of the suffici	of Death rsing Hor	23e. Did to 1 24a. Was autoperforme 5 residence of Check only only only only only only only only	obacco u Yes 2 an Sory 20 No one) dence how injur Street an	23d. Date Monuse contribution of the Monuse cont	a of deliventh ibute to the state of the st	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death? Day Year De cause of death? ably 4 Unknown psy findings available mpletion of cause of 2 No
edical Certification: To Be Completed by Physician/Medical Examiner	region of micanoli, to be completed by ritysical medical Examination	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Early therefore, cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condit. Preumonia 25. Was case referred to medical examiner? 1 Yes 2 Ye	ions con al ling ligation I not be mined ing Phys I Examin	Due to Due to Due to Due to Due to Cospital: 28a. Date (Montal Contal Contal Contact Cont	Acute (or as a consector of a consector of as a consector of as a consector of as a consector of a consector	quence of): quenc	Ectopic production of the state of the model of the state	e of dying Insu UPPO egnancy ecify) ause give ause give in my op	g, such as a support of the support	of Death rsing Hor	23e. Did t 24a. Was autoperfollowed to the sautoperfollowed to the sautoperfo	obacco u Yes 2 an osy med? 20 An one) dence how injur Street an wn, State cause(s) date and	23d. Date Monuse contribution of the Monuse cont	e of deliverable of the state o	Approximate Interval Between Onset and Death Death Onset and D
Certification: To Be Completed by Physician/Medical Examiner	region of micanoli, to be completed by ritysical medical Examination	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. First Uncertainty Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condit. Preumonia 25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown 27. Manner of Death Particular of Death Natural Suicide Gould determined to the condition of the	ions con al ling ligation I not be mined ing Phys I Examin	Due to Due to Due to Due to Due to Cospital: 28a. Date (Montal Contal Contal Contact Cont	Acute (or as a consection of pregretation of p	quence of): quenc	Ectopic production of the state of the model of the state	egnancy ecify)ause give at the time	g, such as a support of the support	of Death rsing Hor	23e. Did t 24a. Was autoperfollowed to the sautoperfollowed to the sautoperfo	obacco u Yes 2 an obay med? 2 No one) dence how injur Street an wn, State cause(s) date and	23d. Date Monuse contribution of the Monuse Contribution of the Monuse o	e of deliventh ibute to the state of the st	Approximate Interval Between Onset and Death Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Death Onset and Death Death Death Death Death Death Death Death Death Death
edical Certification: To Be Completed by Physician/Medical Examiner	region of micanoli, to be completed by ritysical medical Examination	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Early therefore, cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condit. Preumonia 25. Was case referred to medical examiner? 1 Yes 2 Ye	ions con al ling ligation I not be mined ing Phys I Examin	Due to Due to Due to Due to Due to Cospital: 28a. Date (Montal Contal Contal Contact Cont	Acute (or as a consection of pregretation of p	quence of): quenc	Ectopic production of the state of the model of the state	egnancy ecity) ause give at the tim in my op	g, such as a support of the support	of Death rsing Hor	23e. Did t 24a. Was autoperfollowed to the sautoperfollowed to the sautoperfo	obacco u Yes 2 an obay med? 2 No one) dence how injur Street an wn, State cause(s) date and	23d. Date Monuse contribution of the Monuse cont	e of deliventh ibute to the state of the st	Approximate Interval Between Onset and Death Death Onset and D
edical Certification: To Be Completed by Physician/Medical Examiner	medical cer unication; To be completed by Filysicial medical Examinie	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Early therefore, cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condit. Preumonia 25. Was case referred to medical examiner? 1 Yes 2 Ye	ions conditions all Haming tigation I not be mined ing Physi I Examin	Due to Due to Due to Due to Due to Cospital: 28a. Date (Montal Montal cute (or as a consection of pregretation of pregretation of pregretation of pregretation of pregretation of pregretation of linium, Day Year) Inpatient 2 of linium, Day Year) Inpatient 2 of linium, Day Year) In patient 2 of linium, Day Year) In patient 2 of linium, Day Year) In patient 2 of linium, Day Year)	quence of): quenc	er the model enal Fail. Fail. Ectopic prediction of the control	e of dying Insu UPP egnancy ecify) ause give A Other Bc. Injury Work 1	g, such as a sufficial property of the sum o	of Death rsing Hor	23e. Did to the series of the time.	obacco in the control of the control	23d. Date Monuse contribution of the Monuse Contribution of the Monuse o	e of deliventh ibute to the state of the st	Approximate Interval Between Onset and Death Death Onset and D	

DHMH 17 Rev 1/2001

hysici		1 - For State Registrer 1. Decedent's Name (First, Middle, Last,					•			2. Date of D Month December	eath Day		ar	3. Time of Death 14:57 PM
/Medic		4a. Facility Name (If not institution, give	street and number)		4b. City.	Town, or	Location of	of Death	Decemb		County of I		
.xaiiiii	ei		ayujew Me	edial C	مطده	B	alti	mor				Bald	im.	ore.
neral ector	y J	5. Social Security Number 6. Se:		83		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D 10-25-1	irth Day, Year) 922	9. W	Birthp Coun i SCO	
>		Usual Residence of Decedent 10a, State 10b, County		100 City T										
and a	5			10c. City, T		cation							,	od. Inside City Limits 1√□ Yes 2 □ No
289-1	Director	Maryland Howard 10e, Street and Number		Jessu	ıp	10f. Zip	Codo				10a Cit	izen of Wha	t Cour	
10 es	ត់	8676 Mission Road				101. 210	2079	'L				d State		,
ns Za	Funeral	11. Marital Status	12. Was Decedent B	Ever in U.S.	13.	Was Dece			gin? (Sp	ecify Yes or N Rican, etc.)		14. Race		
if item 27 is marked other than "natural", or items 23a or 28e-f show or other treumatic event, the Mudical Examiner must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo		fYes, speo 1 ☐ Yes		Specify:	i, Puerto	Rican, etc.)		Black, \ Specify:	White,	
atura Col E		15. Decedent's Edu		1		dent's Usua					16b. K	ind of Busin	ess/Ind	lustry
E W	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5	+)	life.	kind of wo DO NOT u	rk done d se retired	<i>luring</i> mos:)	t of work	ng				
E 3	5	12			Admin	istrat	ive A	ssista	nt		Stat	e of M	ichi	gan
ced oth	Be	17. Father's Name (First, Middle, Last) Harry Worrel				٠.				<i>(First, Middi</i> an Bree		Sumame)		
i a i	ို	19a. Informant's Name/Relationship (T)	rpe, Print)		19b. Mailir	ng Address	(Street a			al Route Num		or Town, Sta	ite, Zip	Code)
27 is r treu		Robert Dutilly (son)				-				ryland	20794			•
nt: if item y or othe		20a. Method of Disposition 1 ☑ Burial 2 ☒ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		20b. Plac	e of Dispo etery, crei	osition (Nar matory or o	ne of other plac		12-23	-2005	20c. Lo	ocation - Cit	y or To	wn, State
Important: any njury once.		21. Signatura Funeral Service Licens								eck Fune Laurel,			0707	
46		23a. Part1. Enter the disease, or compl	lications that caused	the death.	Do not ent	ter the mod	le of dyin	g, such as	cardiac	or respire tory	arrest,			Approximate
sician edical		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. Sul		1 h	ema	tom	a		A			-	Onset and Death
miner			Due to (or as	oduva a consequen vom b	nce of):	tope	nia		1	1/2 1				1 wear
. 	ner	Sequentially list conditions, if any loading to ammodiate cause. Enter Underlying Cause (Disease or injury	Due to (or as		nce of	,			9	/ hunt	DICAL EXA	MINER		J
ohysicien and the burial-transit	I Examine		c Due to (or as	a consequen	nce of):			PERMIT	N APP	ROVED BY ME			-	
physic the t	dlca		d.										-	
the attending ph thed for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♥ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	eath 3[]Ectopic pi] Other (sp						23d. Date o Month		ry Day Year
signed by the d be detached	by	Part II. Other significant conditions co	ntributing to death bi	ut not resultir	ng in the u	nderlying o	ause give	en in Part I					ite Io th	e cause of death?
should should	ete									240 146			ro auto	au findings available
ate hes page 2	Completed										opsy formed?	prio	r to cor th?	osy findings available npletion of cause of 2 No
is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth.		of Deat	h (Check only	one)			
this aldi	5	1 ★ ★ ENO	1 Sinpatie		VOutpatie	nt 3 DC		4 - 140		me 5 Re 28d. Describ			Specify)
After	atlon	Thateal 5 Pending investigation	28a. Date of Injui (Month, Day 12/2005		Injury		28c. Injun Worl 1 ☐ '	Yes X	1	Proba				
To the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injudently building, etc.	c. (Specify)	e, farm, st	reet, factor	y, office			28f. Location City or T	own, State	nd Number (or Rura	l Route Number,
Funere letely fills	edical (29a. Certifier 1 Certifying Phy (Check only one)	vsician: To the best of iner: On the basis of and manner sta	of my knowle	edge, deat n and/or in	h occurred ivestigation	at the tim	ne, date an pinion, dea	nd place, ith occur	and due to th	e cause(s) and mann d place, and	er as st	ated. the cause(s)
o th	Me	29b. Signature and title of certifier		0		29	c. License	e number			29d. Da	te signed (A	vionth,	Day, Year)
7		Virlette 1	W. Len	and	, M. I	۵. ا -	JHH	# T	117	-7	Dece	imber	- 13	1,2005
		30. Name a address of person who c												

		Please T 1 - State Amend Items 2 Registrar				c. Ensure All Health and M 23/06dhb Death	ental Hygie	_	43889
Physici /Medi			rvis E	dward	2		2. Date of Death Month	Day Year 18 200	3. Time of Death 5 2035P M
Examir	ner	4a. Facility Name (If not institution, give s	,	15 0 - 1		or Location of Death		4c. County of Oea	ath
Funeral		University of Marc 5. Social Security Number 6. Sex	gland Me	allal Cent	day) If Under 1 Yea		8. Date of Birth	MA 9. Bi	rthplace (State or Foreign
Director		218-42-6188	IM 2□F	61 Y	rs. Months Days	Hours Min.	(Month, Day,) Apr. 6		ryland
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
Mary B-f eh	tor	Maryland N/A		Baltime	ore				1X∑Yes 2 No
or 28	Funeral Director	10e. Street and Number			10f. Zip Code			g. Citizen of What C	ountry?
ns 23e	eral	1718 McCulloh	Street # 12. Was Decedent		2121 13 Was Decedent of	Hispanic Origin? (Spe		JSA 14. Race - Am	erican Indian
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumstic event, the Medical Exeminar must be notified at \$00.8.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 28 If Yes, Give Year or Dates:		If Yes, specify Cu	ban, Mexican, Pueπo i	Rican, etc.)	Black, Wh	ite, etc.
"natu	letec	15. Decedent's Educ (Specify only highest grade	cation completed)	(Decedent's Usual Occu Give kind of work done	e during most of workii	ng 10	6b. Kind of Business	s/Industry
withir lene. then	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4or 5	5+)	_{life. DO NOT use retir} echniciar	,	Lo	ocke Ins	ulation
d 2 should be filed th and Mental Hyg i7 is marked other treumatic event,	BeC	17. Father's Name (First, Middle, Last)			ecunicia	18. Mother's Name	(First, Middle, Ma	aiden Sumame)	
ould b Menta arked	To	Richard H. Edwa:				Sarah Pe			
d 2 sh th and 7 is m treum		19a. Informant's Name/Relationship (Type Carla Yvette Nea	-	19b.	Mailing Address (Stree	at and Number or Ryra Lob St			Zip Code) 21217
t Heall		20a. Method of Disposition		20b. Place of I	Disposition (Name of		ate 1 20	ore, Mary Oc. Location - City o	r Town State
Pages nent of I int: If its iry or o		1 Donation 5 Other (Specify)	emoval from State	King	Memorial"	Park 12/	23/05 V	Woodlawn	,Marland
permit. Pages 1 al Department of Hea Important: If Item eny injury or othe		21. Signature of Edneral Service Lives	90		22. Name and Add	ress of FaciliChat	man-Haı	rris Fun	eral Home
40 E 3 0		May Aire	actions that source	d the death. Do as	5240 Re	isterstow	n Rd Ba	altimore	,Md 21215
Physician /Medical	,	25a. Part1. Inter the disease, or complies shock, or hear failure. List only on Immediate Cause (Final disease or condition resulting in death)	subdu	0 1	natoma	ring, such as cardiac o	respiratory arres	51,	Approximate Interval Between Onset and Death
Examiner		Sequentially list conditions)			/ //			
ed isit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):	1/h	W JEDICAL EX	AMINER	
eath certificate be executed ettending physician and for use as the burial-transit	Ical Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence of):	CERTIFICATION APPROA	ED BY MED.		
The law requires that the death certificate be executed to hes been signed by the ettending physician and bage 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		23d. Date of de Month	elivery Day Year
res that the de igned by the be detached	by Pi	Part II. Other significant conditions con					23e. Did toba	acco use contribute t	to the cause of death?
w require been si	ted	Hypertensive At	neroscie	rotic Cai	rdiovascula	ar	1 ☐ Yes	2 No 3 □ P	robably 4 Unknown
	Completed	Disease					24a. Was an autopsy performe	ed? prior to death?	utopsy findings available completion of cause of s 2 \(\text{No} \)
sician: Th certificate rector, pag	o Be	25. Was case referred to medical examiner?	lospital:		_ 10	26. Place of Death			
Attending Physician: r death. sctor: After this certifica	 	1 ☐Xes 200 Ho 27. Manner of Death	1 ≥ Inpation 28a. Date of Injuty (Month, Date)		me of 28c. Inj	4 Nursing Hor	ne 5 ☐ Residen 28d. Describe how	ice 6 Other (Spi v injury occurred	ecity)
uttending death. ctor: Aft	atlo	2 Accident 5 ☐ Pending investigation	12/17/0	5 Unkr	nown M 1	ork? ∐Yes 2 X No]	Probable	fall	
To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, et at	jury - At home, fari tc. <i>(Specify)</i> t. home	n, street, factory, office	e 2	281. Location (Stre City or Town, L718 McC	et and Number or F State) Balti ulloh St.	Rural Route Number, more, MD #1
Hospitel 24 hours a Funerel I	edical	29a. Certifier (Check only one) 2 Medical Examin	sician: To the best ner: On the basis of and manner st	of examination and	death occurred at the for investigation, in my	time, date and place, a opinion, death occurre	and due to the cau ed at the time, dat	use(s) and manner a se and place, and du	s stated. e to the cause(s)
To the To the Complet	Mec	29b. Signature and the of certifier	and manner St	a.eu.		nse number		d. Date signed (Mon	
m > m 0		Ill Surver	WW)		AUIT	76435SISS	502 1	2/18/	2005
		30. Name and address of person who co	mpleted cause of a	death (Item 23a) (T	ype, Print)	ALDES HAD	715	2)	
St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registr	rar's Signature	and books	NAME INITY	4111		

DHMH 17 Rev 1/2001

4C, 349 who tong

Amend item#28a, perME, G854 4/4/06 III

Amend item#28a, perME, G854 4/4/06 III

State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene

Amend Items 23a, PtI, II, 25, 27 28a-ft per ME G853, 03/23/06dhb

Reg. No. 2003 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month JAGODZINSKI DIANA November ZO 00 M 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Maximal Center Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F **Director** 212-16-5984 88 1917 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Directo Harford Abingdon Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21009 USA 2803 Bynum Overlook Drive Funera 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 PNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify: 3 XWidowed 4 ☐ Divorced White traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. d other than " Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Men's Clothing Store 11 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumetical. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (unk) Impallaria Pauline (unk) Coccaqna Joseph 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Wargo - Daughter 2803 Byoum Overlook Drive, Abin don, Maryland 21009
se of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gardens of Faith Cem. 11/16/05 Baltimore, Maryland 21. Sign tur of Fun of Service Licenses McComas Funeral Home, F.A. 22. Name and Address of Facility 1317 Cokesbury Road, Abingdon, Maryland 21009 ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Part1. Enter the disease, or complicated shock, or heart failure. List only one as Approximate Interval Between Onset and Death Pneumonia Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to for as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine CERTIFICATION APPROVED BY MEDICAL EXAMINER The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 physician Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? jo Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Š signed by be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Motor Vehicle Accident with multiple rib fractures/ 1 X Yes 2 No 3 Probably 4 Unknown Flail chest 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 21X No 2 No Hospital or Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28d. Describe how injury occurred

Driver of auto involved in 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 10/19/2004 After Divatural 5 Pending death. 2X Accident 1 Yes 2 XNo investigation 10/23/04 Unknown M Motor vehicle accident after deat Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Rt 924 near Plumtree Rd. 4 Homicide ∩ 24 hour. the Funeral Dire street 29a. Certifier Kortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number NOVEMBER, 11, 2005 RES 00 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CLUWASEUN FALADE, 4940 EASTERN AVENUE, BALTIMORE, NO 21224 31. Date filed (Month, Day, Year)
MAR 2 3 2006 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Items 23a, Pt1, II, 25, 27, 28a-f per MF, C853, 03/29/06dhb Registrar Certificate of Death Reg. No. 3-005 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** CHARLES LEROY BUTLER, JR. December 31,2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital of Baltimore N/ABaltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day) 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 52 9. Birthplace (State or Foreign Days 212-60-8042 **™** M 2□ F Hours 10/14/1953 Yrs. Director MARYLAND Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28e-f show BALTIMORE 1 Yes 2 No MD WINDSOR MILL Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21244 8246 CHURCH LANE, APT. H USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic evant, it's Medical Examiner Black, White, etc. 1 Never Married 2 Married ō BLACK 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Maryland 2121 al Hygiene. Elementary/Secondary (0-12) 12TH College (1-4or 5+) SELF-EMPLOYED LABORER LAWN CARE 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame)
DELORES BENNETT Be markad o CHARLES LEROY BUTLER, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2222 MT. HOLLEY ST., BALTIMORE, MD 21216 JOSEPH BUTLER / UNCLE Department of Health Important: If itam 27 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 01/05/06 CATONSVILLE, MD any injury 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, Patric Enfer the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or year failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Suse (Final diseas) an Londition Priysician with complications Subdural Hematoma resulting in death) /Medical Due to (or as a consequence of): Hypertension; Chronic alcohol abuse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): cocaine use certificate be executed burial-transit Exami DERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (* as a consequence of): resulting in death) Last Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death Month Day Year 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Monknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Xes 2 √ Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 ENatural 5 Pending investigation Unknown 1 ☐ Yes 2 K No Unknown Unknown M 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

68760 P.O. Division of Vital Records,

ō

within 24 hours after death.

To the Funeral Director; A completely filled in by the fu To the Hospital

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Jose

4 - Homicide

29a. Certifier (Check only one) 29b. Signature and title



30. Name and address of per on who completed cau of death (Item 23a) (Type, Print)

32. Registrar's Signature

M

Unknown

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Unknown

29d. Date signed (Month, Day, Year)

		For Amend Items 2 RegistAmend Items 2 1. Decedent's Name (First, Middle, Last	3a PtI,25	,27 per ME 854,04/107	06date	03'/ of L	29/06 Death	dhb'	2. Date of De		2005	-43893
Physici /Medic	al	GLADY S 4a. Facility Name (If not institution, give		Cr	4b. City, To		Location	f Doath	DECEMIL	BER 6	Year 2006 County of Deal	3. Time of Death
Examin Funeral	er	THE Johus Hop 5. Social Security Number 6. Se	KINS HO	Spi FAL (In yrs. last birthday)	BA.	/fr	MOR If Under	24 Hrs.	8. Date of Bir (Month, Da	i	Baltin	nore City hplace (State or Foreignatry)
Director		218-44-0730 Usuat Residence of Decedent 10a. State 10b. County]M 2]S[F	90 Yrs.		Days	Hours	Min.	February 2			Maryland
ith the Marylan or 28a-f show	Director		vard	Too. Only, Town of Ed	10f. Zip Ci		cott City	y		10- Ciai-		10d. Inside City Limit
23a or	al Di	3800 Old Columbia Pike			101. Zip O	000	210	43		rog. Citiz	en of What Co U.S	
72 hours after death with the Maryland natural", or Itams 23a or 28a-f show lical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 Tyes 2 N If Yes, Give Year or Dates:	lo	Was Deceder If Yes, specify	/	spanic Orig n, Mexican Specify:	gin? (Sp , Puerto	ecify Yes or No Rican, etc.)		4. Race - Ame Black, Whit	
within ene. then "	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5	(Give	dent's Usual (kind of work i DO NOT use	doné di retired)	urina most		ing	16b. Kin	d of Business/	Industry Home
il Hygiene. other than	0	17. Father's Name (First, Middle, Last)							e (First, Middle	, Maiden S	Sumame)	
should be filed ind Mental Hygin is marked other umatic avent, I	To B	John Hen	ry Stanton						Fa	nnie F	letcher	
id 2 sho ith and 27 is ma		19a. Informant's Name/Relationship (T)	En o						al Route Numb			(ip Code)
s 1 an f Heal item 2 other		Ms Teressa E. Cross 20a. Method of Disposition		20b. Place of Dispo	sition (Name	of			icott City, N		ation - City or	Town, State
00		1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		Crest Law	•		,	12/	10/2005			e, Maryland
permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Ticens 23a. Part. Enter the disease, or compleshock, or heart failure. List only o	KeiDig	W-	297	ck Fu	uneral H	Home	Dika Ellicat	t City, I	MD 21043	Approximate Interval Between
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		OURAL HE a consequence of):	MATO	m	4 Wi	th c	complica	ntion	s	Onset and Death
ate be executed sysicien and he burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o	a consequence of):	RACI	Fr-1)	L	U APPRO	WED BY MEDICA	LEXAMINE	R	3-24/5
at the death certifics by the attending pl tached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 WNo 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregi	nancy	TIFICATION	N. P.			3d. Date of deli Month	very Day Year
w requires that been signed t should be deta	þ	Part II. Dther significant conditions co						ase,		-		the cause of death?
: The law requ cete hes been page 2 shoul	Completed	Diabetes							24a. Was autor perio 1 \(\text{Yes} \)		24b. Were au prior to death?	topsy findings availab comptetion of cause o
sician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	lospital:			Other			h (Check only o			
g Physier this	n: To	27. Manner of Death	28a. Date of Injur (Month, Day			. Injury Work	4 🔲 Nur	7	me 5 Resident			cify)
or Attanding I fler death. birsctor: After n by the funer	Certification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined		ıry - At home, farm, sti	М	1 🗆 Y	? es 2 □ N	10		Street and		ral Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Ce	29a. Certifier 12 Certifying Phy (Check only one) 12 Medical Exami	sician: To the best oner: On the basis of and manner sta	of my knowledge, deat examination and/or in ted.	n occurred at t vestigation, in	the time	e, date and inion, deat	d place, h occurr	and due to the red at the time,	cause(s) a date and p	ind manner as place, and due	stated. to the cause(s)
To the within To the Comp	M	29b. Signature and title of certifier	Takers	M	R	15	number	ΦØ			signed (Month	
		30. Name and addr ss of person who co	ompleted cause of de	path (Item 23a) Type.	Print) NO/FE	3	TREE	7,1	BAltin	NORE	MI	21287

				artment of Health and Me F ME 0853 03/29/060 rtificate of Death		
Physici /Media		1. Decedent's Name (First, Middle, Last JOHN SAMUEL DI				Day Year 2 0 0 5 9:00 p
Examir		4a. Facility Name (If not institution, give 1023 C. Marine Roa	· ·	4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico
Funeral Director		5. Social Security Number 6. Se 220-09-1149		If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	Date of Birth (Month, Day, Yes	9. Birthplace (State or Foreigner)
a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Wicomico	10c. City, Town or Lo			10d. Inside City Limit
f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28e-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	1023 C. Marine Roa 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No	10f. Zip Code 21801 Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Ric		USA 14. Race - American Indian, Black, White, etc. Specify: Black
ne. nen "natur n Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation 16a. Dece e completed) (Give life.	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	166	b. Kind of Business/Industry
ental Hygiene. ked other than ic event, the Me	Be	8th 17. Father's Name (First, Middle, Last) William	_	er/Dietician 18. Mother's Name (F		
ind Mental s marked umatic ev	To	19a. Informant's Name/Relationship (T)	Duncan (pe, Print) 19b. Mailin	Hattie ng Address (Street and Number or Rural R	Route Number, Ci	Miles ty or Town, State, Zip Code)
Department of Health Important: If item 27 any Injury or other to once.		Charmeka Parker/gr 20a. Method of Disposition 1 Surial 2	20b. Place of Dispo cemetery, crei Mt. Calva	Valley Forge Pk. Rd patrion (Name of natory or other place) ry Ch. Cem. 11/02/2 2. Name and Address of Facility 1213 PLLEY MEMORIAL CH	2005 <u>Fr</u> Jersey	Location - City or Town, State uitland, Maryland Road - Salisbury, M
ysician Medical	W 16	23a. Part1. Enter the disease, or compishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Do not entre cause on each line.	er the mode of dying, such as cardiac or re		21801 Approximate Interval Between Onset and Death
ysician and he burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	CERTIFICATION APPR	AND ROVED BY MEDICA	4 HONTH
has been signed by the attending pt ge 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
en signed b ould be deta	by	Part II. Other significant conditions con Hypertensive at	ntributing to death but not resulting in the uncherosclerotic cardi	nderlying cause given in Part I.	23e. Did tobaco	to use contribute to the cause of death?
icate has be	Completed				24a. Was an autopsy performed 1 ☐ Yes 2 💆	24b. Were autopsy findings availab prior to completion of cause of death? No 1 \(\text{Yes} \) 2 \(\text{No} \) No
within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ation: To Be	25. Was case referred to medical examiner? 152 Yes 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 2 ER/Outpatien 28a. Date of Injury (Month, Day Year) 28b. Time of Injury			6 □Other (Specify) njury occurred
rs after dez al Directo ed in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, stribuilding, etc. (Specify)	eet, factory, office 28f.	Location (Street City or Town, St	and Number or Rural Route Number, ate)
within 24 hours a To the Funeral C completely filled	edicai	29a. Certifier (Check only one) 1 Certifying Physical Cartifying Physical Examination (Check only one)	sician: To the best of my knowledge, death ner: On the basis of examination and/or inv and manner stated.	n occurred at the time, date and place, and vestigation, in my opinion, death occurred a	due to the cause at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
within 24 hours of the Funeral completely filled	Ž	29b. Signature and title of certifier		29c. License number	29d. I	Date signed (Month, Day, Year)
		700 hum		1150420		11 0 15
		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type,	050929		11-8-05

			1 - For Amend Items 2. Registrar	State of M	aryland 25 pe	d / Depa ML G <i>Cer</i>	rtment of I 853,03/2 tificate of	lealth a 9/06dh Death	nd Menta ib	al Hygiei Reg.	ne No. 200	05-4	13894
	Physici	an	Decedent's Name (First, Middle, Last)							e of Death	Day Ye	ar	me of Death
West State	/Medic	al	Earl Paul Holt 4a. Facility Name (If not institution, give s.	treet and number)		4b. City, Town, o	or Location of		mber 28	2005 4c. County of E		30 A. ™
	Examin	er	Future Care-Cherrywood	reet and normoon,	,		Reisterst		Death		Baltim		
Žų.	Funeral Director		213 10 1000	_	ge (In yrs. 1 95	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Dat	e of Birth onth, Day, Ye ober 18,			tate or Foreign
	wo w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Insi	de City Limits
	Mary B-1 eh	tor	Maryland Baltimore		Ba	ltimore						1 🗆	Yes 21 No
	or 28	Funeral Director	10e. Street and Number 4931 Bucks School House	Dood			10f. Zip Code		-		Citizen of Wha	t Country?	
	eeth v	erai	1	2. Was Decedent	Ever in II	S 13 V	21237 Vas Decedent of H	lienanic Orig	in? (Specify Ye	US us or No-		American Indi	20
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heatin and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f ehow appringnts of Item 27 is marked other than "natural", or Itema 23a or 28a-f ehow appringnt output traumatic event. I'm Madical Examinar must be notified at ADRG.	þ	1 Never Married 2 Married 3 🕅 Widowed 4 Divorced	Armed Forces 1 Yes 2 X If Yes, Give Year or Dates:	?	11	Yes, specify Cub	an, Mexican, Specify:	Puerto Rican,	etc.)	Black, V	Vhite, etc.	au,
5-0	72 ho	eted	15. Decedent's Educ (Specify only highest grade	ation completed)		(Give	ent's Usual Occup kind of work done	during most	of working	16b	. Kind of Busine	ess/Industry	
121	within ene. than '	Completed	Elementary/Secondary (0·12)	College (1-4or	5+)	Weld	00 NOT use retire C	d)			onstruct:	ion	
d 2	illed Hygir other	Be Co	17. Father's Name (First, Middle, Last)					18. Mother	's Name (First,			1011	
ylar	Menta Menta arked aric ev	To B	Oliver E. Holt					Martha	M. Fied	ler			
Maryland	12 sho h and 7 is m	8 3	19a. Informant's Name/Relationship (Typ			1	g Address (Street					te, Zip Code)	
	1 and Healt Ism 2		Martha Hopkins/Daughter 20a. Method of Disposition	.	20b. PI	ace of Dispos	eggs Road		nster Mar Date	-	2115/ Location - City	or Town, Sta	ite
altimore,	Pages ent of nt: If I		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State	Garc	metery, crem dens of	Faith	1	2/31/05	Bal	timore M	aryland	
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service License	Christina Hilton			Name and Address eonard J. 305 Harfor	Ruck, II	nc.	re Marvil	and 212	1/1	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that cause	d the death	. Do not ente	or the mode of dyir	ng, such as c	ardiac or respir	ratory arrest,	and 212.	Approx	I Between
Service .	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	<u>&</u>	nd S	trus	Kiner	ra		X		Uni	and Death
	Examiner		1	Due to (or as	a consequ	ience of)			/1	/			
4.	**	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ience of):			114	7			
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	D				(WALD BY MED	CAL EXAMINER		
8760,	cate be executed physicien and the burial-transit			Due to (or as	a consequ	ience or):		CERT	FICATION APPRI	JAEDO			
9	tificate g phys	ledical	d.										
Вох	death certifica e attending pl od for use as t	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	lc. If yes, outcome			Ectopic pregnancy	,			23d. Date of		M.
P.O. E		Physician/Me	1 Yes 2 No	4□Pregnant a 9□Unknown	t time of de		Other (specify)				Month	Day	Year
rds, I	The taw requires that the ofe has been signed by the page 2 should be detached.	þ	Part II. Other significant conditions con	urlung to death t	out not resu	ilting in the un	derlying cause giv	ren in Part I.	23	e. Did tobaco 1 □ Yes	o use contribut	e to the cause	
900	ne taw rec has bee je 2 shor	Completed	WA &	whiten	2	lien	1 tone		24	a. Was an autopsy	24b. Were	autopsy find	ings available
Ä	. The page	Com	Mostate	Con					10	performed Yes 2	/ deat	h? Yes 2 No	
Vita	siclan: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	ospital:			25 DOA O#	00	of Death (Chec				
ō	Attending Physiclan: If death. Cotor: After this certific by the funeral director.	n; To	27. Manner of Death	28a. Date of Inju	ury	ER/Outpatient 28b. Time of	3 DOA 28c. Injur	4 La-Nurs			6 Other (5	Specify)	
ion	ttending death. stor: After	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Da	ly Year)	Injury		'k? Yes 2 □ N	0				
Division of Vital Records,	s efter de al Directo ad in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of In building, e	jury - At ho tc. (Specify	me, farm, stre	et, factory, office		28f. Loc City	ation (Street y or Town, St	and Number of ate)	r Rural Route	Number,
	To the Hospital or Attending Physician: The within 24 hours eiter death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 1 Certifying Physical Cartifying Physical Examin	ician: To the best er: On the basis of and manner st	of examinati	vledge, death ion and/or inv	occurred at the tir estigation, in my o	me, date and pinion, death	place, and due occurred at th	to the cause e time, date a	(s) and manne and place, and	r as stated. due to the cat	use(s)
	To the To the comp	Ň	29b. Signature and title of certifier	Uni	h		29c. Licens	e number	10	29d. I	Date signed (M	onth, Day, Ye	ar)
			1	<i>U</i>	7		1	1275	69		12/2	810)	
			30. Name and address of person who/cor	mpleted cause of a	death (Item / C	23a) (Type, F	Crint)	T	a Re	1 -	2 (2)	c	
***	Sta	_	31. Date filed (Month, Day, Year)	32. Regist	rar's Signat	ure Jose	W	16				9	
7	Registr	ar	MAR 2 9 2006	AND W		1							

		•	1 - State Amend Items	State of Marylar 23a, 25, 27, 28	nd / Departmen	t of Health and 3853,037,29/0	Mental Hygi 6dhb	ene	5-42895
	# · (i)		Registrar Decedent's Name (First, Middle, Last)		Continual	C OI DOUIII	2. Date of Death	9.110.	3. Time of Death
	Physici	an	i / :	Palm	-		Month	Day Ye	ar 1
1	/Medic		Vivian	. Palme		To a selection of Dec	Nou	9 70	
	Examin	-	4a. Fecility Name (If not institution, give s		2 1	Town, or Location of Dea	tn	4c. County of E	eath
R 22			University of Mary			TYPAT If Under 24 Hrs		NA	
	Funeral		5. Social Security Number 6. Sex	M 2 7. Age (In yrs.	Yrs. If Under		. (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
	Director		213-30 3101	7 //	rrs.		July 5, 19	734	N.J
	DC &	1	Usual Residence of Decedent 10a. State 10b. County	10c Ci	ty, Town or Location				10d. Inside City Limits
	aryla eho	<u>_</u>	MalD						1 (es 2 □ No
	8a-f	ctc	NO(1) NA	13	ALTimor				
	g = 1	Director	10e. Street and Number	- , 5 .	10f. Zip	Code	10	g. Citizen of Wha	t Country?
	23a	E	3918 Ge15/0	N Driva	e l	21229		USH	
	G G	Funeral	11. Marital Status	Was Decedent Ever in U Armed Forces?	I.S. 13. Was Dece	dent of Hispanic Origin? (S cify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		American Indian, Vhite, etc.
9	or It	F	1 Never Married 2 Married	1 Yes 2 No	1 ☐ Yes			Specify:	A !
5-0036	ours Frail,	d by	3 Widowed 4 Divorced	Year or Dates:				Specify.	Black
5-6	within 72 hours after death with the Maryland ene. Han "satural", or Iteme 23e or 28e-f ehow he Madical Ezani, ar must te isolitled a	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Decedent's Usua (Give kind of wo	ork done during most of wo	orkina 1	6b. Kind of Busin	ess/Industry
2	thin	jd	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT u	se retired)		./	
2	filed with Hygiene. ther that	Son	12	_3	Nur.	5 e	/	Health	Care
פר	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle, M	laiden Sumame)	
ā	Mental Mental arked atic ev	ToE	ErNEST 57	ewart		J050h	ive 5	Stewar	T
Maryland	S P E E		19a. Informant's Name/Relationship (Ty	Print)	19b. Mailing Address	S (Street and Number or F	Rural Route Number,	City or Town, Sta	te, Zip Code)
Ž	and 2 lealth a m 27 le		Darwell Fal	mer - 500/	4408 B	VANNE AVE	Battimore	m1 21	206
ā,	Hea Hea tem		20a. Method of Disposition	20b.	Place of Disposition (Nat	me of		Oc. Location - City	
3altimore	9 2 5		1 Burial 2 □ Cremation 3 □R	emoval from State	cemetery, crematory or c	41111	1 12-	ri .	11/100
를			4 □ Donation 5 □ Other (Specify)		LVVISON FORE	31 20 10 10 10 10 10 10 10 10 10 10 10 10 10	pu 11,2005 L	wings 1	MIB, MU.
3a	Departi Mport Iny inj		21. Signature of Funeral Service License	98	22. Name ar	nd Address of Facility	200 Liber	y Kood R	1 21133
	707 a d		Molecy		WYLIE	Funeral Hon	ne IH of e	BALLima	· County "11)
17			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the dea e cause on each line.	th. Do not enter the mod	de of dying, such as cardia	ac or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Acula Fe	coin tor	Dietres	5/01/	01.0	Onset and Death
150	/Medical		resulting in death)	Due to (or as a consec	quence of);	DISTICSS	Trail	me	
	Examiner			TransCo	sim rel	what com	6 link	inistra	2-1
Sec.		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):	areo aco	10/19	17901 4	a cacies
	nslt	n n	Cause (Disease or injury	Myelas	14001.00		////		
•	ate be executed hysicien and the buriat-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	ineuce of:	Δ	CERTIFICATION APPRO	-ICAL E	XAMINER
760,	be e icien buris	calE					CO TO ADDROY	NED BY WEDICAL	
	cate phys the						CERTIFICATION AFT		
ж 68	feath certificat ettending phy I for use as th	Me	IF FEMALE:	o- 16					
Вох	death c e ettend ad for us	an	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet	al death 3 Ectopic p			23d. Date of Month	delivery Day Year
	he ed f	sic	1 ☐ Yes 2 ☑ No	4☐ Pregnant at time of o	death 5 Other (sp	pecify)		No.	Day Toal
P.0	thet the ed by th detache	h	9 Unknown						
	5 0 0	by Physician/Med	Part II. Other significant conditions cor			*		acco use contribut	te to the cause of death?
Division of Vital Records,	w requires been signi should be	ed	Hypertensive ath	erosclerotic	cardiovascu	ılar disease	1 Tes	s 2 2 No 3	Probably 4 Unknown
8		Completed	Diabetes				24a. Was an	24b. Wer	e autopsy findings available to completion of cause of
Re	hysicien: The law his certificate has E I director, page 2 s	Ē					autopsy perform	ed deat	h?
a	ficat ficat or, pe	ပိ	OF Was seen referred to medical				1 Yes 2		Yes 2□No
₹	Physicien: this certific ral director,	00	25. Was case referred to medical examiner?	ospital:			eath Check only one		
o	Phys this aldi	٦.	Yes 25 No	1 Inpatient 2	ER/Outpatient 3 D0	DA 4 Nursing	Home 5 Resider		Specify)
2	g e	o	-+ ENatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)		28c. Injury at Work?			to DDDC Conta
Sic	tend leath tor: ,	Certification;	2 Accident investigation 3 Suicide 6 Could not be	10/21/2005	And the second of the second o	1 ☐ Yes ZX No			to PRBC fusio
:≅	irect irect	Ħ	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, factor ify)	y, office	28f. Location (Street) City or Town,	eet and Number o . State)	r Rural Route Number,
	ital c rs af rai D			cancer cent			Universit	y Hospit	
	To the Hospital or Attendivition 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	ician: To the best of my kn ar: On the basis of examin	owledge, death occurred	at the time, date and place	Greene St	use(s) and manne	r as stated?
	he F in 24 he F plete	edi	one)	and manner stated.		., army opinion, death occ	at the time, da	to and place, and	and to the cansa(2)
	To t To t	Σ	29b. Signature and title of certifier	.)	29	c. License number	29	d. Date signed (N	fonth, Day, Year)
	2		1 /1 500	-t un		P19706		11/9/0	5
	1		30 Name an address of person who co		m 23a) (Type, Print)			, 170	
11	•		Robert French			Lines Mr	1 21201		
	C.	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature a	timore, MY	01001		
-	Regist		NOV 1 5 200	5	1 Consules				

DHMH 17 Rev 1/2001

			Amend Items 23	State of Maryla Ba, 25 per ME,	6853,03 Cei	ytment of 729706dh rtificate of	Health and Mei Death	ntal Hygier Reg. t	ne No. 200	5-4389
Г	Physici		1. Decedent's Name (First, Middle, Last MILTON C. W	,			2.		Day Year	3. Time of Death
1	/Medic Examin		4a. Facility Name (If not institution, give FUTURE CARE-HO	e street end number)			4b. City, Town, or Locat BALTIMO	ion of Death	tc. County of Death	
	Funeral Director		5. Social Security Number 6. S 201 46 5478 1	ex 7. Age (In yr.	s. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Dey, Yea EB. 17.	9. Birth Cou 1931 AR	place (State or Foreign ntry) KANSAS
	faryland	5	10a. State 10b. County MD. N/A	10c. 0	City, Town or Lo	cation	D.			10d. Inside City Limits 1 □ Yes 2 □ No
	h with the N 3a or 28a-f at be nortifi	ai Director	10e. Street end Number	REET	DE	10f. Zip Code	21218		Citizen of What Cou	
020	n 72 hours efter death with the Maryland "natural", or Items 23a or 28a-f show adical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Vas Decedent of left Yes, specify Cub	Hispanic Origin? (Specify an, Mexican, Puerto Ric Specity:	/ Yes or No- an, etc.)	14. Race - Ameri Black, White Specify: BLA	, etc.
Maryland 21215-0020	y within jiene. r than The Me	Completed	15. Decedent's Ec (Specify only highest gre Elementary/Secondary (0-12) 5 TH		(Give life. I	DO NOT use retire	during most of working		Kind of Business/Ir	ndustry STRUCTION
yland	Pe di di di di di di di di di di di di di	To Be (17. Father's Name (First, Middle, Last) EMMITT WELLS				18. Mother's Name (F	irst, Middle, Meide		
Mar	d 2 should th end Mer 7 le marks traumetic		19a. Informant's Name/Relationship (1		250000000	2	t and Number or Rurel R			
Baltimore,	Peges 1 end 3 ment of Health ant: If Item 27 I ury or other tr		RANDY WELLS 20a. Method of Disposition 1 Burial 2 Commation 3 D 4 Dopnation 5 Other (Specify	Removal from State	Place of Dispo cemetery, cren	sition (Name of natory or other pla	ER PIKE RI (ce) EMATORY NO	Date 20c.	TOWN, M Location · City or T 2005 BA	own, State
Balti	permit. Pe Depertmen Important: any injury once.		21. Invature of Funeral Service Licen	1 1	22 C	Name and AddreSALVIN		5 FUNER	AL HOME	
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	A	ath. Do not ent	er the mode of dyi	ing, such as cardiac or re	spiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner	J.	Immediate Cause (Final disease or condition resulting in death)	a. Oue to	nuy (or as a conseq	uence of):	y dises	use /	(luleum
	executed n end iel-trensit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to	(or as a conseq	uence of):	1			
c 68760,	ortificete be executed ing physician end e es the buriel-trensit	Medical	Cause (Disease or injury that initiated events resulting in death) Last		(or as a conseq	uence of):	Town B	AV- APPROVED BY MED	ICH EXPRISES	
Вох	eeth certi ettending I for use e	cian/		d						
P. O.	res thet the de igned by the e be deteched f	y Physician/M	Part II. Other algnificant conditions of	ontributing to death but not re	sulting in the ur	nderlying cause gi	ven in Part I.	23b. Did tobacc		o the cauae of death? bably 4-1000 Unknown
cords	requii been s should	Completed by		Subdura	l lu	mone		24a. Was an aut performed?	av	ere autopsy findings ailable prior to empletion of cause death?
E E			р	Denes	Ain			1□ Yes		⊒Yes 2□No
<u> </u>	Physicien: Tribis certifical	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2[□ EB/Outpation	t 3□ DOA Oti	26. Place of Death (C		0	£.3
Division of Vital Records,	Attanding Physic death. ector: After this by the funerel d		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	☐ ER/Outpatien 28b. Time of Injury	28c. Inju Wo	ry at rk? 28d lYes 2 □ No	Describe how inj		y)
Divis	= 5 € 5	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	eet, factory, office	28f.	Location (Street a City or Town, Sta	and Number or Run te)	al Route Number,
	a Hospital 24 hours e Funaral E letely filled	edical	29a. Certifier (Check only one) 12 Certifying Phy	ysician: To the best of my kn Iner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the tirestigation, in my o	me, date and place, and opinion, death occurred a	due to the ceuse(it the time, date a	s) and manner as s nd place, and due t	tated. o the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	, mo		29c. Licens			Pate signed (Month,	
			30. Name and address of person who o	completel cause of death (Ite	em 23a) (Type, I	Print) /83 /	7569 8 Gleen	re Tr	ue M	21200
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 9 2006	32. Registrar's Sign	Apolle	,				

NOVEMBER 03, 2005

MILTON C

DHMH 16 Rev 6/95

amend 20-22 per DVR g853 3/9/06 KBH Sure All Copies Are Legible. g854 4/6/06 KBH State of Maryland / Department of Health and Mental Hygiene amend 3 per Dr. 1 - State Registrar Certificate of Death ent's Name (First, Middle, Last) 2. Date of Death Physician /Medical 4c. County of Death Examiner Maical **Funeral** Months Min. Days Hours Director Usuaf Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a. Ştate 9fty, Town or Location 10d. Inside City Limits work | rthan "naturel", or items 23a or 28a-f showing the Model Examiner must be notified at 1 Yes 2 No Funeral Director Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Efementary/Secondary (0-12) College (1-4or 5+) tant permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 1s marked other any injury or other traumatic event, 9069. 17. Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Maiden Sum 1/2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address, Street and Number or Rural Route N giber, City or Town, State, Zip Code) Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ➡ Other (Specify) 22. Name and Address of Facility

State Anatomy Board

Baltimore, Md. 21201 21. Signature of Funeral Service Licensee 655 W. Baltimore ST Ronald S. Wade (per DVR) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rematurii /Medical to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burial-Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? þ After this certificate has been sign funeral director, page 2 should be 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how infury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury death. 1 Tes 2 No within 24 hours after death To the Funeral Director: completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and married at the time, date and place, and due to the cause(s) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) We 050256 4940 Fastery Ave Nancy Hueppchen, M.D. Baltimore, Md 21224 31. Date filed (Manuf A Pay Year) 2006 State Registrar

2005-43897

				/land / Dep	partment of He	alth and Me	-	ne 15	43895
	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, Last) BAby FANTROY 4a. Facility, Name (If not institution, give street and number)	1	4b. City, Town, or Lo		2. Date of Death Month	Day Year 12 2005 4c. County of Death	3. Time of Death
- 3	Funeral Director	iei	Saint Joseph Medical Gen	n yrs. iast birthday O Yrs.	Tows	SOY) If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, Ye	Baltir (9. Birth Cou	
poelyne M out	28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County 10 MARY/And BALTIMORE 10e. Street and Number	Oc. City, Town or L	Location Salawa 10f. Zip Code				10d. Inside City Limits 1 ☐ Yes 2 No
5-0036	ital Hygiene. stocket then "natural", or items 23a or 28a-f show event, the Micrical Examiner must be notified at	by Funeral Di	10 HANNA COORT 11. Marital Status 1 Never Married 2 Married 1 1 1 9 5 2 No If Yes, Give	r in U.S. 13.	2/24/9 Was Decedent of Hisp If Yes, specify Cuban, 1 □ Yes 2 No			US A 14. Race - Ameri Black, White,	can Indian, etc.
121	giene. erthen "naturel" ine Medical Ex	Completed b	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Dece (Given) life.	edent's Usual Occupation of work done dur DO NOT use retired)	ring most of working	7 16t	Specify: BIA D. Kind of Business/In Infant	
Maryland 2	ind Mental Hy marked other	To Be C	17. Father's Name (First, Middle, Last) DWAYNE LACOUNT FANTRO 19a. Informant's Name/Relationship (Type, Print)	1		8. Mother's Name (ShyNEA d Number or Rural	R. F.	antroy	o Code)
Baltimore, Ma	Department of Health and Merlingortant: If item 27 is marke any injury or other traumatic QDGs.		1 ■ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Disposementary, cre	HAWNA Costion (Name of ematory or other place)	DAT BAH. Da FAY Apa: 1 2 of Facility	mere MA to 200 6, 2006 BA 7601	RYLAND 2. Location - City or To Altimore City OSIER DR.	1244 own, State Y, MARY land
1760,		Jicai Examiner	23 . art . Enter the disease, or complications that caused the scok, or heart failure. List only one cause on each line. In ediate Cause (Final attention of the condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition of the condition of th	on death. Do not en Of Umor on quence of): Lem	nter the mode of dying,	such as cardiac or YES+ YES+	respiratory arrest,		Approximate Interval Between Onset and Death
O. Box 68	e attending d for use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of p 1 Live birth 2 4 Pregnant at time	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deliver	ery Day Year
Vital Records, P.O.	ate has page 2	Completed by PI	Part II. Other significant conditions contributing to death but no	ot resulting in the u	underlying cause given i	in Part I.	23e. Did tobacc	24b. Were auto	he cause of death? bably 4 □Unknown posy findings available mpletion of cause of
Division of Vita	n. After this certific funeral director,	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No		ont 3 DOA Other: Of 28c. Injury at Work? M 1 Yes	t 28	Check only one 5 Residence d. Describe how in	6 ☐Other (Specification)	
DIVI			4 Homicide determined 288. Place of injury building, etc. (S	w knowledge, deal	th accurrent at the time	date and class as	City or Town, St	***	EWI I
Total	within 24 To the F complete	Medical	(Check only one) 2 Medical Examiner: On the basis of examiner stated. 29b. Signature and title of certifier	00	29c. License no			Date signed (Month,	
<i>H</i>			30. Name and address of person were completed cause of death SHEVEN MOUSHELL M.	D. 768	Di Osler	Drive T	Towson	MD ZIZ	04
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 3 2006 Registrar's	Signature	346				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Physician Month Dev Vear Kaymond Bechler 1835 Wember 21 2005 /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Birth Min. (Month, Day, Year) 70 5. Social Security Number 6. Sex Baltimore If Linder 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 ♥ M 2 □ F Vrs Director November 21,2005 Mary Usuel Residence of Decedent death with the Merylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pagas 1 end 2 should be filed within 72 hours after death with the Merylen Depertment of Health end Mental Hygiena. Important: if item 27 is marked other than "naturel; or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland estminster 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 | 12. Was Decedent Ever in U.S. Armed Forces? | 1 | Yes. 2 | Yes. Give/ Year or Dates: USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Completed by 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be bavid Bechler Lynn Nicole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BOX 2312 21158 Nicole Bechler 3 Pate, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 1 Burial 2 profession 5 Nother (Specify) Hosp Dropped Hospita 21. Signature of Funeral Service Licenses 22. Name and Address of Facility DALMMOR JINAI HOSPITAL 2401 W. Belvipeee Aux, nongste 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Completed by Physician/Medical Examiner law requires that the death certificate be executed ig physician and es the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) attending physician for use es the burie Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): esn Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably PPROM @19 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ils certificate has been s director, pege 2 should 1 ☐ Yes 2 No 200 No 1 Tyes or Attending Physician: 25. Wes case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: Medical Certification: To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this filled in by the funerel 27. Manner of Death 28a. Date of Injury (Month, Dey 28b. Time of injury 28d. Describe how injury occurred Director: After 1 Naturel
2 Accident 5 Pending investigation death. 1 Yes NA 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as steted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 17/00 6529 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Heather Kipa-Joseph, MD W. Belvedere A Hospita 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 6 2006 Registrar

ORIGINAL

DHMH 16 Rev 6/95

29cd, 30 perplease Type of Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 200 Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 355 0 J-onzalez /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deatl Examiner J. Age (In yrs. last birthday) epra If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex ff Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days Months 1□ M 2004 NONE Director 20 mar Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location Show 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f shor Injury or other traumatic event, the Medical Examiner must be notified at 1 Xes 2 No Directo 10e. Street end Numb 10f. Zip Code 10g. Citizen of Whet Country? SA 15809 070 2 Funeral 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: ۵ Specify: Mexican 3 Widowed 4 Divorced MEXICAN 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry end Mentel Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Ntani + Nfani NONE NON 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LIKNOWN Lugenia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 809 Maria ruj:1/0 Depertment of Heelth Important: If Item 27 Eugenia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete CHEVERLY, MD 03-06-20% 4 Donation 5 DOther (Specify) Release to Hospital P.G.H.C22. Name and Address of Facility P.GH.C. 21. Signature of Funeral Service Licenses any. 3001 HOSPITAL DRIVE, CHEVERLY, MD 20785 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physicien end s the burial-trensit To the Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Division of Vital Records, P.O. Box 68760 Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 🗹 No 3 Probably 4 Unknown 1 Yes þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 🗆 Yes 2 19 No 1 Yes 2 No After this certificate 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Yes, 2 No Other: 1 DInpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Injury at Work? 1 12 Naturel 5 Pending investigation death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0055135 10/10/05 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Eenest Adadevoh 3001 hospital Dr Cheverly, MD.

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year) APR 0

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 23a, Pt II, 2532/11/28a-f. PS-all, G854.04/10/06dhb 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 17 2005 Daniel C Herring Sr 5:05 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Ivy Hall Nursing Home Baltimore County Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, B. Date of Birth (Month, Day, Year) January 23 1956

9. Birthplace (State or Foreign Country)
Baltimore, Maryland **Funeral** 7. Age (In yrs. last birthday) 1 ☐ M 2 ☐ F Yrs Director 218 68 5964 49 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show treumatic event, the Medical Examinar must be nutified at Director 1 ☐ Yes 2 ☑ No Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 4 Torhat Court Apt. L USA Items 23e Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 9 1 ☐ Yes 2 ☐ No Specify: ð Specify: 3 ☐ Widowed 4 X Divorced White natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry iit. Pages 1 and 2 should be filed within entment of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 $\mathbb{N}A$ Truck Driver Herring & Sons Asphalt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clarence Herring Sr Janet Becker 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Herring 4 Torhat Court Apt L Baltimore, Maryland 21221 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ō Metro Crematory Inc Oct. 19 2005 Baltimore, Maryland permit.
Deportuimporte
any nit 22. Name and Address of Facility Lassann Funeral Home 21. Skin ture of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and De Immediate Cause (Final **Physician** diac disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and s the burial-tran CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): hat the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ö in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Paraplegia due to neck injury 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes Z Other: P 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending Injury investigation 06./26/1986 1 Yes 2 No Slipped and injured neck 2 X Accident Unknown^M Director 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Harford Road., Balto., MD within 24 hours a To the Funerel C pool 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALI (A WASSEM 709.

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

709.

BLVD-

EASTERN

			-	State of	f Marylar	nd / Depa					ental H		ne	•	
		1	For State Registrar		,				Death			_	10.2005	-4390	2
o,			1. Decedent's Name (First, Middle,	_ast)							2. Date of D	eath	Day Yes	3. Time	of Death
	sicia: edica		MONET H	Ι.	KENL	AW					June	6,	2005	1400	O M
	mine	r	4a. Facility Name (If not institution, g				1 '		Location of	f Death			c. County of D	eath	
			niv. of Maryla				-	ltir		14 Mgc					
Fune		1	5. Social Security Number 6	. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs.	last birthday) Yrs.	Months	n 1 Year Days	If Under 2 Hours	Min.	8. Date of B	ay, Ye	9.	Birthplace (State	
Direc	tor	-	Usual Residence of Decedent							[]	6/6	/ 20	505 M	arylan	<u>u</u>
yland	4	.	10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside	
e Ma		55	moryland 150	Hmor	e B	altmo	STC					,		1 □ Ye	s 2K No
or 28		Funeral Director	10e. Street and Number	1	0	1		p Code				10g.	Citizen of What	Country?	
ath w	Teat.	- a	3009 Pan		Kua	4		515		-:-2 (0		1.	USA	marian Indian	
ter de Item		Ÿ.	11. Marital Status 1 KNever Married 2 Married	Armed F		1.5.	If Yes, sp	ecify Cuba	an, Mexican	, Puerto	ecify Yes or N Rican, etc.)	10-	Black, W	merican Indian, hite, etc.	
ING 21215-UU36 be filed within 72 hours after death with the Maryland ntal Hygiene. d other than "natural", or flems 23a or 28a-f show			3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or D	ve		1 Tes	2 🔼 No	Specify:				Specify:	Shite	
2 ho	1201	Completed by	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Us	al Occup	ation during most	of worki	na	16b	Kind of Busine	ss/Industry	
within 72 ene. than "nat	- Mari	ng l	Elementary/Secondary (0-12)		1-4or 5+)	life.	DO NOT	use retired	1)	or works	,,g	-	TO	1	
filed w		ဂ် ပ	<u> </u>	0		<u> </u>	Int	CNT		1. 1/-	15 . A.C		Infa	1	
land	9 0	To Be	17. Father's Name (First, Middle, La	· 1	- 1	. V.	رما ۔		4.4				ion Sumamo) (ath 15		
Maryland d 2 should be file th and Mental Hy 7 is marked oth	maric L	٩	19a. Informant's Name/Relationship	ewis - L	angle		na Addres		Le ()		ANN I Route Num		y or Town, Stat		
			Kelly mathis	(moth	erl	300					ad			md.	21222
S 1 ar	Injury or other traumatic B.	- 1-	20a. Method of Disposition	_	20b. I	Place of Diene	neition (N	ma of	1	Г	late	200	Location City	or Tours State	
Pages nent of nnt: If It	i d		1 ☐ Burial 2 🗖 Cremation 3 1 ☐ Donation 5 ☐ Other (Spe		State	west	wegi	00/0	enter J	Tune	9.200	5 1	altmo	re mar	yland
Baltimore, permit. Pages 1 ar Department of Hea Important: If Item	any inju		21. Signature of Funeral Service Li	censee Din	ta- Ans	לים לי	2. Name a	nd Addre	ss of Facility	225	Atric	Grei	ne Stree	+ Bult,	md.
n 855	S S		heentk	-Su Pu	owo "	M	INGS	JY G	FINA	MIC	Nation	dic	at Center	212	101
	9		shock, or heart failure. List or	omplications that nly one cause on	caused the dea each line.	th. Do not en	ter the mo	de Y dyin	ig, such as	cardiac o	or respiratory	arrest,		Approxim Interval E Onset an	Between
Physic			Immediate Cause (Final disease or condition resulting in death)		treme		turi	ty						1Hour	
/Medi Exami	_		1030 mily in deality	Due to	(or as a consec	quence of):									
1200		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a consec	quence of):								-	
uted	ansit	Examiner	cause. Enter Underlying Cause Oicease or Injury that initiated events	0											
3760, ate be executed nysician and	Tal-I	Exa	resulting in death) Last	Due to	(or as a consec	quence of):									
8760 ate be e hysician	ng eu	cal	•	d											
BOX 68 death certificat	98	by Physician/Med	IF FEMALE:	22 o H vos o	itcome of pregn	2004			-						-
Box eath cert attendin	io io	ian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fet	al death 3	☐Ectopic		1				23d. Date of Month	delivery Day	Year
. 0 0	ched	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unki		Joan St	_ Outlot (poury) _							
Records, P.O. The law requires that the ste has been signed by th	e deta	Y P	Part II. Other significant condition	s contributing to	death but not re	sulting in the u	underlying	cause giv	en in Part I.		23e. Die	tobaco	o use contribut	e to the cause of	of death?
Records, P The law requires that the has been signed to											1 [] Yes	2 □ No 3 □	Probably 4	Unknown
Reco		piet									24a. Wt	is an	24b. Were	autopsy finding to completion o	gs available
The The ate hg	page	Completed										formed	? deat	1?	. 00000
of Vital Re hyaician: The la his certificate has	actor,	Be (25. Was case referred to medical examiner?	Manital				04			(Check only				
Of Of Physis of this of	al dir	٦.	1 Yes No 27. Manner of Death	Hospital: 1 []	Inpatient 2	ER/Outpatie		OA Diur	4 Nu				6 Other (S	Specify)	
ding l	funeral	tion	1X Natural 5 Pending	(Mo.	nth, Day Year)	Injury	M	28c. Injur Wor	k? Yes 2⊟!		Zou. Describ	B HOW II	ijary occurred		
Division of Vital or Attending Physician: after death. Diractor: After this certifica	y the	fica	3 Suicide 6 Could no	ot be 28e. Plac	e of Injury - At h	nome, farm, st								Rural Route N	umber,
Div alor s after	d in b	Certification:	4 Homicide	buile	ding, etc. (Speci	ify)					City or 7	own, Si	ate)		
Dir To the Hospital or within 24 hours after To the Funeral Dir	completely filled in by the		29a. Certifier Certifying	Physician: To the	e best of my kn	owledge, dea	th occurre	d at the tir	ne, date an	d place,	and due to th	e cause	(s) and manne	r as stated.	9(5)
To the H within 24 To the F	nplete	Medical	one)	and ma	nner stated.	41101141100111		9c. Licens							
5. ¥ 5	200	-	29b. Signature and title of certifier	0.00										onth, Day, Year	
			30. Name and address of person w	bo completed car	ise of death lite	m 23a) /T		P158) Q T			Ма	rch 17	, 2006)
				in, MD				tree	+ R	al+	imore	M	d 2120	1	
	Sta	te	31 Date filed (Month, Day, Year)	32	Registrar's Sign	atyles d	reels	1	- C 1	.	VI C	التا م	L L C U	<u></u>	
Re	gistr	ar	MAR 2 3	2006	The state of	1									

		4	For State	State of Maryland / I	Department of Health and	d Mer	ital Hygi	iene	~~	100.0
			Registrar 1. Dependent's Name (First, Middle, Jas) Ma 0 4	Certificate of Death	2.1	Re Date of Death	g. No. <u>//</u>	00-9	3. Time of Death
	hysicia /Medic	in al	10 any 150	ay 11167	leil		Month	28	05	3 39 M
Ε	xamin	er	a. Fecility Name (If not institution give	oxidet and number) Hos	14b. City, Folym, or Location of Di	eath	The	4c. County	of Beath	•
	ineral		Social Security Number 6. 9	x 7. Age (In yrs. last bit	rthday) If Under 1 Year If Under 24 H	Aig. (Date of Birth Month, Day,	Yegr) _	9. Birthpl	ace (State or Foreign
ō	ector		Usual Residence of Decedent				7/28	3/00		y kyuna
Marylar	show ind at	0.0	10a. State 10b. County	11/60d 10c. City, Tow	altimore	0			10	0d. Inside City Limits 1 ☐ Yes 2 No
with the Maryland	or 28a	Director	10e. Street and Number	and a -Ci	10f. Zip Code		10	g. Citizen of	What Count	•
death w	ns 23a	Funerai I	t 1. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin?	Specify	Yes or No-	14 Bac	29 - America	A Indian
OU36 hours after o	ral', or items 23s or 28s-f show Examiner must be notified at	by Fun	1 Never Married 2 Married	Armed Forces 1 ☐ Yes 2 No If Yes, Give	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	uerto Rica	n, etc.)		ck, White, e	
2 hours af	natural dical Ex		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	Decedent's Usual Occupation		1	6b. Kind of B	10/	ustry
	r than "natu It e Modical	Completed	(Specify only highest grad	College (1 4 or A+)	(Give kind of work done during most of life. DO NOT use retired)	Working		_	Dal	ant
nd Z be filed al Hygie	d other	Be Co	17. Father's Name (First, Middle, Last)	, , , , , , , , , , , , , , , , , , ,	18. Mother's r	Name (Fig	st, Middle, M	faiden Sumar	ne)	nate 1
rylan hould be d Mental	marke	ဥ	19a. Mormant's Name/Relationship (7	vpe. Pont). 4 19th	D. Wertling Address (Street and Nymber or	49	KOM.	a Le	9/1	Mell
and 2 sh	er trau		LaResha L	10 Meil/mothers:	228/edur	All	ne ()4K/4	nomi	115 21045
ore ore ore	t; If item 2		20a. Method of Disposition 1 Burial 2 Cremation 3	Reproved from State / cemete	f Disposition (Name of ry, crematory or other place)	1/28	1 2 c	Oc. Location	City or Tov	Ne mil
Baltim permit. Pag Department	Important: any injury once.		` 4 □ Donation 5 Other (Specify 21. Signature of Funeral Service Licen:	10-1-1-1	22. Name and Address of Facility	1/20	ا روماره	Jul 1	(100)	n. walkst
n &&.	e e e		(Jeno	race	Johns H	upl	inst	Jospita	Ball	imiremous
Phys	sician		Immediate Cause (Final	one cause on each line.	not enter the mode of dying, such as card	till o	spiratory arres	1 1 LQ L	fa 2	Approximate Interval Between Onset and Death
/Me	dical		disease or condition resulting in death)	a. Due to (or as a consequence	of):	VD. (2		111104	voy	p 20 juns
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence	of):		· <u> </u>			
recuted	sician and burial-transit	Examin	cause. Enter Underlying Cause (Disease or infury that initiated events resulting in death) Last	c Due to (or as a consequence	of):					
8 / 60, ate be execu	physician the buria	dicai E		d	oi).					
		യ	IF FEMALE:	23c. If yes, outcome of pregnancy						
. BOX 6	been signed by the attending should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live birth 2 Fetal death 4 Pregnant at time of death	3 Ectopic pregnancy 5 Other (specify)				te of deliver inth [y Day Year
Pat the	d by th		9 □ Unknown Part II. Other significant conditions α	9 Unknown	a the underhing course given in Red I		220 Did tob	2000 1100 2001	ribusa sa sha	and death?
Kecords, P.O.	uld be	Ω	anni, onioi signinoani conancio di	Antibotaly to death but not resulting i	in the underlying cause given in Parti.	_				e cause of death?
Meco The law re	2 5	ompieted					24a. Was an autopsy	24b.	Were autop	sy findings available ipletion of cause of
	pag	e Cor	25. Was case referred to medical					ed?	death?	Σ X μο
	s in	To B	examiner? A.	Hospital: 1 Inpatient 2 ER/Ou	26. Place of Dother: 4 Nursing			nce 6 Oth	er (Specify)	,
C & 3	atter iner		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b.	Fime of njury 28c, Injury at Work? M 1 Yes 2 No			v injury occur		
DIVISION I or Attending after death.	rector: by the	ertification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa		28f. L	ocation (Stre	et and Numb	er or Rural	Route Number,
pital o	erał Di	OL								
DIVISIO To the Hospital or Attendi within 24 hours after death.	he Fun pletely	edicai	(Check only 2 Medical Exam	iner: On the basis of examination an and manner stated.	e, death occurred at the time, date and pla d/or investigation, in my opinion, death oc	ace, and o ccurred at	the time, dat	use(s) and ma te and place,	and due to t	ted. :he cause(s)
To H	Con	Σ	29b. Signature and title of certifier	ASING	29c. License number	(-		d. Date signe		
2 H			30. Name and address of person who c	ompleted cause of death (Item 23a)	(Type, Print) 2 (C 2 (0		7/7/	00	21205
Di 1 1			Mader	sura 600	n. Wolfest	10	atri	mou	nul	des
F	Sta Registra	_	APR'0°6 20	06 Registrar's Signature						

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** ANDERSON MENDOZA MIKE 07:40 AM 08 AUGUST 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE SAINT JOSEPH MEDICAL CENTER TOWSON 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** NONE Director 8,2005 August MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and temper 15 er marked other then "naturel", or Iteme 23 eor 28 e-1 ehow 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-1 show other treumstic event, the Modical Examinar must be notified at Cockeysville 1 Yes 2 No BAltimore Courty Directo MARYLANd 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10034 Hill GREEN CIRcle Apt. D 21030 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: wnite 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INFANT 0 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be f Health and Menta 2 MIKE ANDERSON Valma MARIA MEDRANO MENDOZA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mike MENdOZA + Velma ModRANG (PARENTS) 10034 HillGREEN CIRCLE A.t. D Cockeys ville, md. 21030 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite eny injury or ot SEPTEMBER 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hely REDGEMER CEMETERY 2005 BAI timeRE City, MARY land 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7601 OSIER DRIVE St. Jeseph Medical Center TOWSON, Md. ZIZOY Wallet 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 53 min I hR. disease or condition /Medical resulting in death) Examiner PREMATURITY - PRE VIABLE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ě in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? g 2₽No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this cartificate 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Impatient 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funaral (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Bloke drent D47798 AUGUST 8, 2005 30. Name and addr ____f person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON, MARYLAND 21204 m.D 6 20082. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

-21	9ac	Per F.H. \$854se 4/6606 PK per Dr. State of M	laryland / Department of	Health and Mental F	lygiene
v .		Registrar	Certificate o	f Death	Reg. No. 2005 - 43905
Physic		Brooks	Stavitzs	Ki Marc	Day Year
/Medi Exami	_	4a. Facility Name (If not institution, give street and number		, or Location of Death	4c. County of Death
K.				imore	Baltimore
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. A Usual Residence of Decedent	de (In yrs. last birthday) If Under 1 Yea Yrs. Months Day 30	s Hours Min. Month,	Birth place (State or Foreign Country) Mel, 2005 Mary land
death with the Maryland ms 23s or 28s-f show Emust be notified at		10a. State 10b. County	10c. City, Town or Location	· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits
036 ours after death with the Marylan al., or Itams 23e or 28e-f show Examination notified at.	Director	MD Charles	Waldorf		1 ☐ Yes 2 ☐ No
with ti		10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?
death ms 23	Funeral	12640 Willow View P1. 11. Marital Status 12. Was Deceden	2060 t Ever in U.S. 13. Was Decedent of	f Hispanic Origin? (Specify Yes or	No- 14. Race - American Indian,
15-0036 72 hours after dea "natural", or Itams		Armed Forces 1 Never Married 2 Married 1 Yes 2	i? If Yes, specify Cu No 1 ☐ Yes 2 1 ☑ No	uban, Mexican, Puèrto Rican, etc.) lo Specify:	Black, White, etc.
	d by	3 Widowed 4 Divorced Year or Dates:			Specify: white
21215-0036 d within 72 hours aft giene. r then "natural; or ins Medical Event	plete	15. Decedent's Education (Specify only highest grade completed)	life. DO NOT use reti	ne durina most of working	16b. Kind of Business/Industry
laryland 212- 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M.	Completed	Elementary/Secondary (0-12) College (1-4or O	infant		infant
ind be file tal Hy id oth	Be (17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Midd	dle, Maiden Sumame)
Maryland d 2 should be file th and Mental Hy i7 Is marked othe traumatic event,	2	Thomas John Stavitzski	10: 14-15- 111 (0)	Crystal Lee Kr	
		19a. Informant's Name/Relationship (Type, Print) Thomas John Stavitzski (f			nber, City or Town, State, Zip Code)
or Health	1 3	20a. Method of Disposition	20b. Place of Disposition (Name of	Date	20c. Location - City or Town, State
Page Page nent o ant: If ury or		1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Hanover Green C	em. 4/5/06	Hanover Twp, Pa. 1870
Baltimore, permit. Pages 1 ar Department of Hea Important: If item any injury or otha		21. Signature of Funeral Service Licensee	22. Name and Add		
m g0= g0	2.	Jonathan F. Stegura (23a. Part1. Enter the disease, or complications that cause		F.H., Inc. 614 S e. Pa. 18634	
Physician /Medical Examiner	iner	Sequentially list conditions. b. Seps	ninated Intraverse a consequence of): (S s a consequence of):	ascular Coagi	ulation Kladay Liday
58760, icate be executed physician and s the burial-transi	cal Examiner	resulting in death) Last Due to (or as	1 I Schemia saconsequence of): ne Prematuriti	у	Liday
O. Box (ie death certif the attending hed for use a	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Live birth			23d. Date of delivery Month Day Year
s that the ned by	y Pr	Part II. Other significant conditions contributing to death	but not resulting in the underlying cause of	given in Part I. 23e. Die	d tobacco use contribute to the cause of death?
cords, w requires been sign should be	ed t	Hnemia	*	1]Yes 2 No 3 Probably 4 □Unknown
Vital Records, sician: The law requires to certificate has been signe lirector, page 2 should be or	Completed by	Patent ductus ar	teriosus	24a. Wt au pe 1 [] Yes	topsy prior to completion of cause of death?
F Vital Rysician: The is certificate his director, page	Be	25. Was case referred to medical axaminer?		26. Place of Death Check onl	A
Vision of Vital Attending Physician: r death. actor: After this cartification the funeral director.	<u>구</u>	1 Yes 2 No Hospital: 1 Inpat 27. Manner of Death 28a. D. te of Inj			esidence 6 Other (Specify)
ion or ading lath.	tlon	1 Natural 5 Pending (Month, Day 2 Accident investigation	<i>ay Year)</i> Injury W	ork? ☐ Yes 2 ☐ No	e how injury occurred
Division of all or attending Phy safter death. I Diractor: After this d in by the funeral d	Certification;	3 Suicide 6 Could not be determined 28e. Place of Ir	njury - At home, farm, street, factory, office tc. (Specify)	e 28f. Location City or 7	(Street and Number or Rural Route Number, rown, State)
Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best 2 Medical Exeminer: On the basis of and manner s	t of my knowledge, death occurred at the of examination and/or investigation, in my tated.	time, date and place, and due to the opinion, death occurred at the time	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)
To tha within 2 To the complet	Ň	29b. Signature and title of certifier	29c. Licer	nse number	29d. Date signed (Month, Day, Year)
		Mer 11. 1 Jugh	D	60452	3/31/05
		30. Name and address of person who completed cause of Kevin N. 50VKin, M		olfe Street Px	Himore, Maryland 202
			trar's Signature	VITE SITEL IL	LHIMOVE, MULYJUNG 36

		•	1 - For Stete Registrar		State o	f Marylai	nd / Depa	artmen rtificat					Reg. No.,	2005-	43 906
	Physicia	an	1. Decedent's Name (First, M	iddle, Last)	110							2. Date of D Month	Death Day	Year	3. Time of Death
1	/Medic	al	DO \ 4a. Facility Name (If not instit	ution give s	treet and nur	mber)		4b. City	Town, or	Location	of Death	June	1/ 4c.	スののと County of Death	1705 PM
	Examin	er	Univ of MIT		lical	Cent	er	Ba	2.1.	more				555, G. 256	•
	Funeral Director		5. Social Security Number	A 6. Sex			. last birthday) Yrs.	If Under Months	P1 / '	If Under Hours			Birth Day, Year)	Cot	place (State or Foreign intry)
	72 hours after death with the Maryland natural; or items 23a or 28a-1 show dical Exaction trust be oviitied at		Usuel Residence of Deceder 10a. State 10b. Co			_	ity, Town or Lo								10d. Inside City Limits
	he Ma	ecto	IND			Ba	Him		0.1.				10-0%		1 Yes 2 □ No
	with t	Dir	10e. Street and Number	10/0	luce	111 4	211	10f. Zip	Code	1-			10g. Citiz	zen of What Cou	intry?
	death	Jera	3 00 7 Thow	aure	2. Was Dece	edent Ever in I	U.S. 13.	Was Deced	tent of Hi	spanic Ori	igin? (Spe	ecify Yes or N	No- 1	4. Race - Amer	
36	be filed within 72 hours after death with the Marylan ital Hyglene. ed other then "natural", or items 23a or 28a-1 show or other then "natural", or items 23a or 28a-1 show event, its Macilcal Examination in the mail to calified at	Completed by Funeral Director	1 Never Married 2		Armed Fo 1 ☐ Yes If Yes, Giv	2X No		1 ☐ Yes :	11	n, mexicar Specify:		Hican, etc.)	-	Black, White Specify:	1 - 1.
ö	hours fural	ed b	3 Widowed 4 Divo	dent's Educ	Year or D	ates:	16a Dece	dent's Usua	I Occupa	ation			16h Kir	nd of Business/l	19CK
21215-0036	within 72 ene. then "na	piet	(Specify only his Elementary/Secondary (0-	ghest grade		I-4or 5+)	(Give	kind of wor DO NOT us	rk done d se retired	luring mos)	t of worki	ng			
21	e filed within al Hygiene. I other then "	Con	0		0			NIA	+				1	NFAN	/
Maryland	intal H intal H ind off	Be	17. Father's Name (First, Mic		1							(First, Midd		Sumame)	
Ž	should be nd Menta marked umatic ev	ဥ	19a. Informant's Name/Rela				19b. Maili	ng Address						Town, State, Z	ip Code)
_	and 2 ealth a m 27 is		Zenobia Da	V15 /	Moth	er	300	7 Th	orn	dale	. AI	ie A/	+#4	baltim	or MD
ore	of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremat	ion 3⊟R	emoval from		Place of Dispo	osition (/van	ne or	e) 1	L	ate	20c. Lo	cation - City or 1	own, State
Baltimore,	it. Partitude ritant		* 4 □ Donation 5 ☑ Other				NIV	0+	MD			1- <u>0</u> 5		alt.	(n)
Ba	Depa Impo any i		Whill B	Wea	they	wo		22 5	s, e	RECH	1F 5	TIEST	134 L	THO2	1201
1	Physician /Medical		23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	e, or compli List only or	EX	aused the dea each line. FYEMC (or as a conse	Prem	ter the mod		g, such as	cardiac o	r respiratory	arrest,		Approximate Interval Between Onset and Death
	Examiner	_	Sequentially list conditions, if any, leading to immediate	ь								-			
	ited I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	₹	Due to	(or as a conse	quence ot):								
oʻ	sician and burial-transit		that initiated events resulting in death) Last	٥		(or as a conse	equence of):								
8760,	- × 0	dicai		C.											
O. Box 6	death certifii e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2	1 Live b	tcome of pregr birth 2 Fet nant at time of own	tel death 3	⊒Ectopic pr ⊒ Other (sp					. 2	3d. Date of deli-	very Day Year
, P.O	res that the de igned by the a be detached		Part II. Other significent con	ditions cor	tributing to de	eath but not re	suiting in the u	nderlying c	ause give	en in Part I	l.	23e. Did	d tobacco u	se contribute to	the cause of death?
rds	law requires that the as been signed by th 2 should be detache	ed by										10	Yes 2]No 3□Pro	bably 4 Unknown
Records,	9 4 9	Completed										24a. We	topsy formed?	24b. Were aut prior to o death? 1 ☐ Yes	opsy findings available ompletion of cause of
Vital		BeC	25. Was case referred to me examiner?	_					1		e of Death	(Check only			
of	Phys this ral dii	To:	1 ☐ Yes 2 No 27. Manger of Death		lospital: 1 □ I 28a. Date	/	ER/Outpatie			4 🗆 140		ne 5 Re 28d. Describe		Other (Spec	ify)
on	Attending I r death. ector: After by the funer	tion	1 Natural 5 □ Pe	ending restigation	(Mon	th, Day Year)	Injury	м	8c. Injury Work	k?` Yes 2 □		204. 0030110	o now injury	occurred	
Division	r Attendi ter death. irector: A irector: A	Certification:	3 ☐ Suicide 6 ☐ C	ould not be termined	28e. Place buildi	of Injury - At I	home, farm, st	reet, factory	, office		- 1	28f. Location City or T	(Street and	Number or Ru	ral Route Number,
	pital o		29a. Certifier 1 🔀 Cer	ifving Bhu	loloni To the	book of my lea	and also dead	h	-4.45 - 41.4						
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical	(Check only 2 Med one)	ical Exami	ner: On the b	asis of examin ner stated.	nation and/or in	n occurred vestigation	at the tim , in my op	ie, date an pinion, dea	ath occurre	and due to the	e, date and	and manner as place, and due	stated. to the cause(s)
	To the To the Comp	Ž	29b. Signature and title of ce	rtifier	,					number				signed (Month	
0	H		John -	_>	· · · · ·			1	<u>)3</u>	63	83		Ap	ril 4	, 2006
16	7.11		30 Name and address of pe	1	poleted caus	1	m 23a) (Type, 2 Z	Print) Sout	4	Gree	112:	5/ F	n/hin	iare n	, 2006 1D 31201
	Sta		31. Date filed (Month, Day,	'ear)	32	legistrar's Sigr	nature	el	5 /	. ,	-1 - 6	1 pm	w (71 //	iore, 10	11 9/201
	Registi	ar	APR :	3 20	06	A Comment	1	100							

			1 For State	State of I	Marylan	d / Depart	ment of He	ealth and N	lental Hygi		
	Physici		Registrar 1. Decedent's Name (First, Middle,	EARL	HAU		CLUNS		2. Date of Death Month	g. No. 2003 Day 2005	3. Time of Death
	/Medi Examir Funeral			ADVENTS1	Age (In yrs.	PITAL 41 (ast birthday) 11	ROCKU	Location of Death	8. Date of Birth	4c. County of Dec	
	Director		Usual Residence of Decedent	12 M 2□F		Yrs.	onths Days	Hours Min.	09 01	2005	MARYLAND
	the Marylau 28e-f show	ector	10a. State 10b. County MD 10e. Street and Number	NTGOMER		AAITHE	RSBURG)			10d. Inside City Limits 1 Yes 2 □ No
	be filed within 72 hours after death with the Maryland nat Hygiene. Ind other than "natural", or items 23a or 28e-1 show event, I'm Medical Examiner must be nuitilised at	Funeral Director	866 QUINCE	12. Was Decede	BL ent Ever in U.	VD#202	Decedent of His	878 panic Origin? (Sp , Mexican, Puerto		g. Citizen of What C	erican Indian,
-0036	hours after tural', or it	ed by Fu	1 Never Married 2 Marrie 3 Widowed 4 Divorced 15. Decedent	1 Tes 2 If Yes, Give / Year or Date	No	10	Yes 2 No	Specify:		Black, Wh	UHITE
21215-0036	filed within 72 Hygiene. Ither then "ne int, Ize Medic	Completed by	(Specify only highest	college (1-4	or 5+)	(Give kind	d of work done du NOT use retired)	iring most of work	ing	6b. Kind of Busines:	
Maryland	should be filed within and Mental Hygiene. I marked other than umatic event, Ira M	To Be (17. Father's Name (First, Middle, L	WN		T		TISH	e (First, Middle, M MAR1E	HAYE	5
Baltimore, Mar	es 1 and 2 and 2 of Health ar		19a. Informant's Name/Relationsh TISH HAYES 20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp	MOTHER 3 Removal from Sta	ite O	19b. Mailing A 866 lace of Disposition emetery, cremato	PUINCE n (Name of	ORCHA	RO BLUD	City or Town, State, # ZOZ (Oc. Location - City o	GAITHERSBURG
Baltin	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service L		010		ame and Address		0	ER DRIVE	Rockville
	Physician		23a. Part 1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition	complications that cause on each	sed the death h line.	RESPIR	e mode of dying,			st,	Approximate Interval Between Onset and Death
	/Medical Examiner	Je	resulting in death) Sequentially list conditions, if any leading to immediate	b. E.	as a consequ X TR6 as a consequ	me	PREMA	TURITY	/	<u> </u>	27775
8760,	ate be executed hysician and he burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	as a consequ						
Box 6	ne death certificate the attending phys thed for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcor 1 Live birth 4 Pregnant	2 ☐ Fetal tat time of de	death 3 □Ect	opic pregnancy ner (specify)			23d. Date of de Month	ilivery Day Year
rds, P.O.	w requires that tl been signed by should be detac	þ	Part II. Other significant condition	is contributing to deat	h but not resu	alting in the under	lying cause given	in Part I.	23e. Did toba		o the cause of death?
Vital Records,	: The law re cate has bee page 2 sho	Completed							24a. Was an autopsy performs	prior to	utopsy findings available completion of cause of
Vita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital: 🗸			0	,	(Check only one)		
ō	ding Ph J. After th funeral	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat			ER/Outpatient 3 28b. Time of Injury	28c, Injury a Work?	4 Nursing Ho	me 5 Residen 28d. Describe how	ce 6 □Other (Sperinjury occurred	ocify)
Division	tel or Atters safter des	Certification	3 Suicide 6 Could no 4 Homicide determin	289. Place of	Injury - At ho etc. (Specify	me, farm, street,	factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	one)	Physician: To the be xaminer: On the basis and manner	or examinat	wledge, death occion and/or investi	gation, in my opir	nion, death occurr	and due to the cau ed at the time, dat	se(s) and manner a e and place, and du	s stated. e to the cause(s)
1.	5 th C	2	29b. Signature and title of certifier	war	M	D	29c. License r			Date signed (Moni	
.6	H.		30. Name and address of person w	e. 9901 /	nt death (Item NEDICA	23a) (Typg. Prin 9L (EN)	ER DRIV	E, Roca	KVILLE 1	74 14 20 MARYLAND	20850
	Sta Registi	_	31. Date filed (Month, Day, Year)	0 2008 ^{32. R. Si}	strar's Signat	ure	we				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 25,27,28a.bper145685404 / 19 064bb 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician 1034 PM 3 2005 December Dessie Frock /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Valtimore - /timore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 227-18-8968 1 □ M 2 X F 81 Yrs. Director January 06,1924 Virginia Usual Residence of Decedent the Maryland 10a State 10h. County 10c. City. Town or Location 10d. Inside City Limits traumatic event, the Mudical Examiner must be notified at 1 ☐ Yes 2 🙀 No Director Woodlawn MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 6744 Fox Meadow Road Completed by Funeral 21207 United States of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married Married 1 Yes 2 No Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Educator Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil ment of Health and Mental H lant: If item 27 is marked otl Be William Bryant Dessie Lever 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald S. Frock 6744 Fox Meadow Road, Woodlawn, Maryland (Spouse) 21207 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) ō Department of important: if any injury or once. Lorraine Park Cemetery 12/08/05 Woodlawn, Maryland 21207 21. Signature of Foneral Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors, Inc 8728 Liberty Road, randallstown, Maryland 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final and Death **Physician** Subdurn disease or condition resulting in death) COUNT /Medical Examiner Sequentially list conditions, CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner dany leading to immedia cause. Enter Underlying Cause (Disease or injury burial-transit resulting in death) Last Due to (or as a consequence of) Medical Certification; To Be Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? tailure 1 Yes 2 No 3 Probably 4 Unknown anticoagulation 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an performed occlusion 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Xes 2 76 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury Hink 28b. Time of Unk 28c. Injury at Injury Work? 27. Manner of Death 28d. Oescribe how injury occurred 5 Pending investigation 1 Fillatural 1 ☐ Yes 2 🗹 No within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be Suicide 28f. Location (Street and Number or Rural Route Number, Place of Injury - At hor building, etc. (Specify) At home, farm, street, lactory, office 4 Homicide 6744 Fox Mealow Rd To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 025861 12-06-05

Registrar

State

32. Registrar's Signature

Bruce R. McCurdy MD. 716 Maiden Choice Lane Suite 101 Baltimore, Maryland 21228

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) APR 1 9 2006 3c.

		1 - State Registrar				- Jai y lai l		rtificate				1ental Hy	Reg. No	.200	5-	439	09
Physicia	an	1. Decedent's Nat EVERRO	, ,	le, Last)			BARR	ייידי				2. Date of D Month March	Da	3 20	Year	3. Time o	
/Medic		4a. Facility Name	(If not institutio	n, give street	and number	er)			Town, or	r Location o	of Death	March		c. County of		0238	_a '
			of Ma		d Med	lical	Ctr		timo					n/a			
neral ector		5. Social Security		6. Sex		Age (in yrs. ia	Ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of B (Month, D March	<i>av. Year</i>	2005		place (State intry)	r Forei
r 286-f ehow	or	Usual Residence 10a. State	10b. County	/			, Town or Lo									10d. Inside C	•
or 28e-	Director	10e. Street and N	lumber			Woo	dlawn	10f. Zip	Code				10g. C	itizen of W	hat Cou		-X-
atte		6005	Prince	George	e St			21:	207				US			,	
aminerma	Funerai	11. Marital Status	rried 2□ Mar	rried Ar	/as Deceder med Force ☐ Yes 2 E Yes. Give	nt Ever in U.S s? No		If Yes, spec	offy Cuba	an, Mexicar	n, Puerto	ecify Yes or N Rican, etc.)	10-	Black	- Ameri , White	ican Indian, , etc.	
al Exam	d by	3 Widowed	4 Divorced		ear or Dates			1 ☐ Yes		Specify:				Specify:	В	lack	
I're Medica	Completed	(Sp	ecify only highe		n <i>pleted)</i> ollege (1-4d	or 5+)	(Give	dent's Usua kind of wor DO NOT us	rk done d	durina mos	st of work	ing	16b. F	Kind of Bus	iness/Ir	ndustry	
ther t		17. Father's Name	0 e (First, Middle	(ast)	_0		in	fant		18 Mothe	ar's Name	e (First, Middle	a Maida	infa			
item 27 is marked other ther other treumetic event, It e N	To Be	Everalv	Barret	t						Tia	Harr	ison					
7 is n treun		19a. Informant's			rint)							al Route Numi					
fitem 2 r other		Ella L. 20a. Method of D		on			ace of Dispo	osition (Nan	ne of	7		Wood1			212 City or T	own, State	
			2 □ Cremation 1 5 □ Other (\$		al from Sta		metery, cre g. Mem			(8)	3/2	26/05	Ran	dalls	:tow	n, MD	
Importent: i any injury o once.	ĺ	21. Signature of I	Funeral Service	Licensee				2. Name an		on of Englis		.0,05	JAKAAA	KICLI I.K.	LOW	11, 110	
Importent: I any injury o		Ga	ry P. M		/	nm 1					*		_			1 0	
		23a, Part1, Enter			(per		G	ary P	. Ma	rch F	uner	al Hom		altin	юrе		
edical		23a. Part1. Enter shock, or he Immediate Caus disease or condit resulting in death	r the disease, o eart failure. Lis e (Final tion	r complication t only one cau	ns that caus use on each Pren	sed the death	G. Do not en	ary P	. Ma	rch F	uner			Baltin	юre	Approxima Interval Be Onset and 8 Min	e ween Death
edical miner	niner	shock, or he Immediate Caus disease or condit resulting in death Sequentially list cause. Enter Unit	r the disease, of part failure. List of (Final tion Inconditions, the district of the deriving Inconditions, the district of t	t complication t only one cau	Pren	sed the death i line. natur:	ity ence of):	ary P	. Ma	rch F	uner			Maltin	ore	Approxima Interval Be Onset and	e ween Death
edical miner	Examin	Immediate Causi disease or condi- resulting in death	r the disease, o eart failure. Lis e (Final tion i)) conditions, im, ediate derlying or injury its	a b	Prender to (or a	sed the death n line. natur: as a consequ	Go. Do not en	ary P	. Ma	rch F	uner			Baltin	ore	Approxima Interval Be Onset and	e ween Death
attending physician and in policy for use as the burial-transit constant in policy for use and the burial-transit constant in policy for use and the burial-transit constant in policy for use and the burial-transit constant in policy for use and the burial-transit constant in policy for use and the burial-transit constant in policy for use and the burial-transit constant in policy for use and the burial-transit constant in policy for use and the burial-transit constant in policy for use and the burial-transit constant in policy for use and the burial-transit constant in policy for use and the burial-transit constant in policy for use and the burial-transit constant in policy for use and the burial-transit constant in policy for use and the burial-transit constant in policy for use and the burial-transit constant in policy for use and the burial-transit constant in policy for use and the burial-transit const	Examin	shock, or he Immediate Caus disease or condi resulting in death Sequentially list cause. Enter Unicause (Disease that initiated ever	r the disease, open failure. Lise (Final tion)) conditions, in the date of the deriving or injury at the deriving or injury at the deriving or injury at the deriving or injury at the deriving or injury at the deriving or injury at the deriving or injury at the deriving or injury at the deriving or injury at the deriving or injury at the deriving of the deriving	b c. d	Prender to (or a yes, outcon	matur: as a consequ as a consequ as a consequ as a consequ as a time of de	ity ence of): ence of):	ary P	e of dying	rch F	uner			23d. Date Moni	of deliv	Approxima Interval Be Onset and 8 Min	e ween Death
gned by the attending physician and Upper De detached for use as the burial-transit De per Record to the action of the period of the action of the actio	by Physician/Medical Examin	shock, or he immediate Causidisease or condiresulting in death Sequentially list of the cause. Enter Unicause (Disease that initiated ever resulting in death IF FEMALE: 23b. Was deceded in the past 1 — Yes 2	the disease, oper failure. Lise a (Final lion lion lion lion lion lion lion lio	a b c 23c. if 1[44] 9[Prender of the control of the contro	as a consequence of pregnar 2 Fetal at time of de	ity ence of): ence of): ence of):	erry P	egnancy	rch F	uner cardiac o	or respiratory	arrest,	23d. Date Moni	of delivith	Approxima Interval Be Onset and 8 Min	e ween Death ut 6
been signed by the attending physician and in particular transit in in in its should be detached for use as the burial-transit in in its should be detached for use as the burial-transit in in its should be detached for use as the burial-transit in its should be detached for use as the burial-transit in its should be a should be	by Physician/Medical Examin	shock, or he immediate Causidisease or condiresulting in death Sequentially list of augustian Cause (Disease that initiated ever resulting in death of the cause Charlet in the past 1	the disease, oper failure. Lise a (Final lion lion lion lion lion lion lion lio	a b c 23c. if 1[44] 9[Prender of the control of the contro	as a consequence of pregnar 2 Fetal at time of de	ity ence of): ence of): ence of):	erry P	egnancy	rch F	uner cardiac o	23e. Did	tobacco	23d. Date Moni	of deliving of del	Approxima Interval Be Onset and 8 Min	e ween Death ute
In this peer signed by the arendining physician and ingine in the perial-transit ingine in the perial-transit in ingine in the perial-transit in ingine in the perial-transit in ingine in the perial	Physician/Medical Examin	shock, or he immediate Causidisease or condiresulting in death Sequentially list of ause. Enter funcause (Disease that initiated ever resulting in death of the cause of the c	the disease, oper failure. Lise a (Final lion lion lion lion lion lion lion lio	a b c 23c. if 1[44] 9[Prender of the control of the contro	as a consequence of pregnar 2 Fetal at time of de	ity ence of): ence of): ence of):	erry P	egnancy	rch F	uner cardiac o	23e. Did	tobacco	23d. Date Moni use contril X No 3 24b. W pr	of deliving of del	Approxima Interval Be Onset and 8 Min	e ween Death Ut (
ecriticate has been signed by the attending physician and incorporate 2 should be detached for use as the buriat-transit in incorporate 2 should be detached for use as the buriat-transit incorporate 2.	Be Completed by Physician/Medical Examin	shock, or he immediate Causidisease or condiresulting in death Sequentially list of the sequential	r the disease, oper failure. Lise (Final tion 1)) conditions, in the distributions of the first tion	b c 23c. if 1 44 gi	Due to (or a pregnant Unknown ting to death	sed the death nine. Matur: as a consequ as a consequ as a consequ as a consequ as a consequ but not resu	ity ence of): ence of): ence of): ence of): elicy death 3[ath 5[ary P. ter the mod □Ectopic pr □ Other (sp	egnancy ecity)	en in Part I	cardiac of	23e. Did 1 24a. Wa auto per 1 Yes	tobacco Yes 2 s an apsy ormed?	23d. Date Montuse contril	of deliving of deliving the deliving of deliving the deliving of deliving the deliving delivi	Approxima Interval Be Onset and 8 Min 10 Approximation of the cause of	e ween Death Ut (
this certificate has been signed by the attending physician and Signed by the attending physician and Signed by the attending physician and Signed by the attending by Signed By the Sig	To Be Completed by Physician/Medical Examin	shock, or he immediate Causa disease or condiresulting in death Sequentially list of the cause. Enter Unicause (Disease that initiated ever resulting in death of the causalting in death of the causalting in the past of the causalting in the past of the causalting in the past of the causalting in the past of the causalting in the past of the causalting in the past of the causalting in the past of the causalting in the past of the causalting in the past of the causalting in the	r the disease, open failure. Lise a (Final tion tion tion tion tion tion tion tion	a b c 23c. If 1/4/9! ions contribut Hospitz	Due to (or a pregnant of the pregnant of the Unknown ting to death	matur: as a consequ as a consequ as a consequ as a consequ as a consequ but not resu attent 2 E	ity ence of): ence of): ence of): ence of): ence of): ence of):	□Ectopic pr □ Other (sp	egnancy ecity)	en in Part I	cardiac of cardiac of Death	23e. Did 1 24a. Wa aut per 1	tobacco Yes 2 s an opsy formed? 20 No	23d. Date Mont use contril No 3 24b. W pr de o 1[of deliving of del	Approxima Interval Be Onset and 8 Min 10 Approximation of the cause of	e ween Death Ut (
tor: Atter this certificate has been signed by the attending physician and in in the funeral director, page 2 should be detached for use as the burial-transit in in it.	To Be Completed by Physician/Medical Examin	shock, or he immediate Causidisease or condiresulting in death Sequentially list of ause. Enter includes (Oisease that initiated ever resulting in death I Sequentially Was deceded in the past 1 Sequentially Yes 2 Sequentially Sequentially Yes 2 Sequentially Sequentially Sequential Sequ	r the disease, open failure. Lise (Final tion)) conditions, in the district deriving or injury at the district deriving or injury at the district deriving or injury at the district deriving or injury at the district deriving or injury at the district deriving de	a b c. d 23c. If 1 4 9 9 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Due to (or a yes, outcom Pregnant Unknown ting to death	as a consequence of pregnar 2 Fetal at time of death at t	ence of): ence of ence of): ence of ence of): ence of ence of): ence of ence	ter the mod	egnancy ecify)ause give	en in Part I	cardiac of Death	23e. Did 1 24a. Wate perf 1 Yes 1 (Check only me 5 Res 28d. Describe	tobacco Yes 2 s an opsy formed? Cone) sidence how inju	23d. Date Mont use contril 24b. W pr de o 1[of deliving of deliving the state of the sta	Approxima Interval Be Onset and 8 Min 10 Provided By Min 10 Provided B	e ween Death Ut (
tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit of the funeral director.	Certification: To Be Completed by Physician/Medical Examin	shock, or he immediate Causidisease or condiresulting in death Sequentially list of ause. Enter Incause (Disease that initiated ever resulting in death In the past 1 Yes 2 9 Unknow Part II. Other sign 25. Was case refexaminer?	r the disease, of eart failure. Lise of (Final tition 1) conditions, the delaying or injury at the disease of the conditions of the condi	a b c d 23c. If 1 1 4 9 1 9 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Due to (or a Due t	matur: as a consequ as a conseq	ity ence of): en	The second of th	egnancy ecify) ause give	en in Part I 26. Place er: 4 \(\) Nu y at k? Yes 2 \(\)	cardiac of Death	23e. Did 1 24a. Waauti 1 Yes In (Check only me 5 Res 28d. Describe	tobacco Yes 2 s an opsy ormed? One) sidence how inju	23d. Date Moni use contril 24b. W pr de o 1 L 6 Other ury occurre	of deliving of deliving of the state of the	Approxima Interval Be Onset and 8 Min 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	e ween Death Ut (
Funerel Director: After this certificate has been signed by the attending physician and ely filled in by the funeral director, page 2 should be detached for use as the buriat-transit of ely filled in by the funeral director, page 2 should be detached for use as the buriat-transit of ely filled in by the funeral director, page 2 should be detached for use as the buriat-transit.	To Be Completed by Physician/Medical Examin	shock, or he immediate Causidisease or condiresulting in death Sequentially list of ause. Enter funcause (Disease that initiated ever resulting in death I great that initiated ever resulting in death I great that initiated ever resulting in death I great that initiated ever resulting in death I great that initiated ever resulting in death I great that initiated ever resulting in death I great that initiated ever resulting in death I great that initiated ever resulting in death I great that initiated every great that initiated ev	r the disease, of eart failure. Lise of (Final tion) conditions, terredistred derying or injury tises and pregnant 1.2 months? 2 m	c. d 23c. If fill fill fill fill fill fill fill f	Due to (or a Due t	matur: as a consequ as a consequ as a consequ as a consequ as a consequ as a consequ as a consequ as a consequ as a consequ as a consequ as a consequ as a consequ as a consequ as a consequ as a consequ as a consequ as a consequ as a consequ but preparat a time of de an but not resu atient 2 E	ity ence of): en	Tectopic production of the sectory of the sector of the sectory of the sector of th	egnancy ecify) ause give A Other Work of, office at the tim in my op	26. Place er: 4 Nu y at Yes 2 ne, date an pinion, dea	cardiac of Death	23e. Did 1 1 24a. Wa. autoper 1 1 Yes 1 (Check only me 5 Res 28f. Location City or Te	tobacco I Yes 2 s an opsy ormed? Cone) sidence how inju (Street a. wm, State	23d. Date Monti use contrib 24b. W pr de o 1[6 Other ury occurre and Number ele)	of deliving of deliving of deliving of deliving of deliving of the control of the control of the control of deliving of the control of the co	Approxima Interval Be Onset and 8 Min 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	e ween Death Ut 6
n. Her this certificate has been signed by the attending physicis funeral director, page 2 should be detached for use as the bu	edical Certification: To Be Completed by Physician/Medical Examin	shock, or he Immediate Causidisease or condiresulting in death Sequentially list of the sequential	r the disease, open failure. Lise (Final tion) conditions, the distriction of the final tion of the f	c. 23c. If 11 44 90 15 15 16 16 16 16 16 16 16 16 16 16 16 16 16	Due to (or a present of the basis on the basis of the bas	matur: as a consequ as a conseq	ity ence of): en	ter the mod Control of the courred divestigation, P.	egnancy ecify) ause give A Other Work of, office at the tim in my op	en in Part I 26. Place er: 4 \(\text{Nu} \) y at k? Yes 2 \(\text{Impe, date an pinion, deale an number} \)	cardiac of Death	23e. Did 1 24a. Waauti 1 Yes In (Check only me 5 Res 28d. Describe	tobacco I Yes 2 s an opsy ormed? One) sidence how inju (Street a. wm, State a cause(s, date an 29d. Da	23d. Date Monti use contrib 24b. W pr de o 1[6 Other ury occurre and Number ele)	of deliving of deliving of the state of the	Approxima Interval Be Onset and 8 Min 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	e ween Death Ut (

amend 21,22 per hosp. Please type of Friffi in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 7:30 AM Dec 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner opvins Bow Baltmor JOHNS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) Funeral 1 M 2 X F Months none Director 2005 Maryland Usual Residence of Decedent death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23a or 28a-f show othar traumatic event. It a Modical Examinat near collised at 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 0 2060 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other then "natural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify Whit 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Infant 17 Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) Be William ٥ 19a. Informant's Na e/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WIEW 940 ONNS TIME 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State HODKINS BOUVIEW Department of important: If any injury or once. 4 Donation 5 Other (Specify) Dec 5, 2005 Bathway 22. Name and Addres of Facility 21. Signature of Funeral Service Licenses Bayview Medical Center, Baltimore, MD 21224 Gerrun March (per DVR) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 5-cuartinly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be axecuted attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by 1 d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificete has been si rector, page 2 should t Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 TYes the Hospital or Attending Physician: After this certific tuneral director, Be (25. Was case referred to medical 26. Place of Death Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural 5 Pending n 24 hours after death.

The Funeral Director: A bletely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Textifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title 29d. Daje signed (Month, Day, Year) 00062954 06

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address

31. Date filed (Month, Day, Year)

Eastern

Ave

Baltimore

of person who completed cause of death (Item 23a) (Type, Print)

DIESCHEN

5 2006

APR 2

4940

32. Registrar's Signature

	Dougra		FOR	partment of Health and li	Mental Hygier	- 7(1())	5 43911
	7 %		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
1	Physici /Medic	- 9	David Douglas		NOVEMBER	5,2005	9:05A. M
1	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	h	4c. County of Dear	th
2		ž	2307 F. CHASE STREET 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	BALTIMORE av) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State or Foreign
	Funeral [*] Director		unk 1⊠M 2□F 56 Yrs	Months Days Hours Min.	Jul 19, 1	ar) Co	yland
100	D		Usual Residence of Decedent				10d. Inside City Limits
	show	2	10a. State 10b. County 10c. City, Town of				1X Yes 2 □ No
	the M	ecto	MD Baltin 10e, Street and Number	10f. Zip Code	10g.	Citizen of What Co	ountry?
	3a or	Funeral Director	443 S. Wickham Road	21229	US		
	death me 2	nera	11. Marital Status 12. Was Decedent Ever in U.S.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No-	14. Race - Ame Black, Whit	
92	72 hours after death with the Maryland naturel; or teme 23a or 28a-f show pical Examinar must be notified at	y Fu	1 Never Married 2 Married 1 Yes 2 No UTIK	1 ☐ Yes 2 ☒ No Specify:		Specify:	
21215-0036	hours turel',	ed by	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. D	ecedent's Usual Occupation	16h	b1. Kind of Business	ack
7	in 72	Completed	(Specify only highest grade completed) (C	ive kind of work done during most of world DO NOT use retired)	nkina	altimore	•
212	d with giene.	шо	Elementary/Secondary (0-12) College (1-4or 5+) 11 none Cler	k		ourt Hous	
2	al Hyg	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Na	ne (First, Middle, Maid	len Sumame)	
yla	ould by Ment	10	Joseph Morton	Hager D		T- 01-1-	7-0-1-1
Maryland	d 2 sh th and 7 le m traum			ailing Address (Street and Number or Ru			zip Code)
<u>ත</u>	Heall Heall tem 2		20a Method of Disposition 20b. Pface of D	08 Goodnow Rd. Balt		Location - City or	Town, State
ē	Pages ent of nt: If I		1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ♣ Other (Specify) in state	crematory or other place)			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Health and Mental Hygiene. Important: If term 27 is marked other than "naturel; or Iteme 25a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.		21. Signature of Funeral Service Licensee Ronald S. Wade Director	22. Name and Address of Facility State Anatomy Boar	rd 655 W. B	Baltimore	Street
200 B	- A.S		23a. Part Enter the disease, or complications that caused the death. Do not	Baltimore, MD 2120 enter the mode of dying, such as cardiac			Approximate Interval Between
	Physician		shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a No ANATOR (C	OR TOXICOLOGIC	(ALDE A	F DEATH	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of)	TO TO TO COOLE	011036 0	VUMIN	
30%	LAMINITE	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of)				
	nsit	nine	cause. Enter Underlying Cause (Disease or injury				
Ć	centificate be executed nding physician and use as the burial-transit	Examiner	that inflated events resulting in death) Last C. Due to (or as a consequence of)				
8760,	ite be iysicia ne bur	icai	d				
89	artifica ing ph e as th	Med	IF FEMALE:				
Вох	death certific le attending p	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of del Month	ivery Day Year
	y the d	ysic	1 Yes 2 No 9 Unknown	3 Citier (specify)	_		
	es that the de igned by the be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part f.	23e. Did tobacc	o use contribute to	the cause of death?
rds	- · · · · · ·	ed b			1 🗆 Yes	2 □ No 3 □ Pr	obably 4 Kunknown
of Vital Records,	e law requ has been je 2 should	Completed			24a. Was an autopsy	prior to	utopsy findings available completion of cause of
<u>=</u>	The este	Con			perfor <i>m</i> ed 1 ⊠ Yes 2☐1		2 No
Vita	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	0	ath (Check only one)		
ō	Phys rthis raldii	1: 10	1	Mishit 3 DOA 4 Divursing P	lome 5 Residence		cify) SCENE
on	Attending I or death. ector: After by the funer	atlor	1 □ Natural 5 □ Pending (Month, Day Year) Inju	Work? 1 □ Yes 2 □ No	VNKNOW	N	
Division	after death after death Director: /	Certification;	3 ☐ Suicide 4 ☐ Homicide 5 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, Sta	and Number or Ru	ural Route Number,
ā	irs after or rai Dir		FOUND - RESIDEA	CE	2107 CHASE		LE MD
	To the Hospital or Attending Physician: within 24 hours alter dealh within 24 hours alter dealh cross to the Funceal Director: After this certific completely filled in by the funeral director,	Medicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, c 2 Medical Examiner: On the basis of examination and/c and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occu	o, and due to the cause arred at the time, date a	e(s) and manner as and place, and due	s stated. Ito the cause(s)
	vithi To t	Σ	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Mont	h. Day, Year)
,			· Unes C	O.C.M.E.	NOVI	EMBER 6,2	2005
			30. Name and address of person who completed cause of death (frem 23a) (Ty	pe, Print) 111 PENN STREET	RAI.TIMORE N	ΜΑΡΥΤ.ΔΝΙΌ	21 201
257	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	TIT TIME OTHERS	PARTITION I		
	Registr		JUN 0 6 2006 Been & for	West -			

		State of Maryland	/ Department of Health an Certificate of Death	d Mental Hygiene Reg. No. 05 - 439 /	2
		Decedent's Name (First, Middle, Last)	Commodite of Dodgi	2. Date of Death 3. Time of D	eath
hysic Medi/		Male Willi	ams	12 01 05 204	-9
Exami		4a Fecility Name (If not institution, give street end number) RINCE GEORGE'S HOSPITAL (or Location of Death 4c. County of Death FRINCE GEORGE'S	
uneral		5. Social Security Number 6. Sex 7. Age (In yrs. let	st birthday) If Under 1 Year If Under 24	Hrs. 8. Date of Birth 11/11/05 Birthplace (State or	-oreign
ctor		1 ☑ M 2 □ F Usuel Residence of Decedent	Yrs. 19	12-61-65 USA	
23e or 28a-f ehow ust be notified at		10a. State 10b. County 10c. City,	Town or Location	10d. Inside City	
	Director		WASHINGTON	10g. Citizen of What Country?	. □ No
		10e. Street end Number 5086 Just St	10f. Zip Code 20019	USA	
	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin If Yes, specify Cyban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
Xamin	by Fu	1 Never Married 2 Married 1 Yes, Give 1 Yes, Give 4 Divorced 7 Year or Detes:	1 ☐ Yes 2 ☑ No Specify:	Specify: BLACK	
lical E		15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working 16b. Kind of Business/Industry	
then the Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Iffe. DO NOT use retired) INFANT	INFANT	
Vent,	BeC	17. Father's Name (First, Middle, Last)	Tarana and American Company	Name (First, Middle, Maiden Surname)	
marked other imatic event,	To			FILA WILLIAMS or Rural Route Number, City or Town, State, Zip Code)	
27 ia n r traur		19a. Informant's Name/Relationship (Type, Print) SHEILA WILLIAMS (MOTHER)	5086 JUST ST	WASHINGTON, DC 20019	
r othe		20a Method of Disposition 20b. Pla	be of Disposition (Name of netery, crematory or other place)	Date 20c. Location - City or Town, State	
mportant: If any injury or pace.		4 □ Donation 5 Ø Other (Specify) #DSPITAL	P. G. H.C.	12/01/05 CHEVERLY MD	
Departm Importa any inju		21. Signature of Funeral Service Licensee Service Licensee MD.	22. Name and Address of Fecility P.G.+, C 300/ 4	HOSPITAL DR CHEVERLY MD	1 40
Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) a. Hypexic Due to (or a b.	-Ischemic 2 is a consequence of): failu	ncephalopathy	
ig physician end es the buriel∹ransit	_	if eny, leading to immediate cause. Enter Underlying Cause Oblegato or injury	s a consequence of):		
ettending pl for use es t	/Mec	d	/		
d for L	Physician/Medical	Part II. Other significant conditions contributing to death but not resulti	ng in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of	death?
Jetecne			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1 Ves 2 No 3 Probably 4 U	
	d by			24a. Was an autopsy 24b. Were autopsy fin	dings
Suo	Completed			performed? available prior to completion of cau of death?	ISØ
añac	Com			1 Yes 2 N 1 Yes 2 N	0
	Be	25. Was case referred to medical examiner?	Other	Death (Check only one)	
1		1 ☐ Yes 212 No 103 1 122 Inpatient 2 ☐ Ef	VOutpatient 3LI DOA 4LI Nursir	ng Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred	
Herel director,	P	27. Manner of Death 28e. Date of Injury 2	8b. Time of 28c. Injury at Work?		
	P	1 Natural 5 Pending (Month, Dey Year)	Injury Work? M 1 Yes 2 No	2006 Leasting (Charatteed Number of Parel Pouts Abresh	
	P	investigation	M 1 Yes 2 No	28f. Location (Street and Number or Rural Route Number City or Town, State)	or,
stely filled in by the funeral director, i	Certification: To	2 Accident 3 Suicide 4 Homicide Could not be determined 28e. Plece of Injury - At hom building, etc. (Specify) Check only Medicat Examiner: On the basis of examination	M 1 ☐ Yes 2 ☐ No e, farm, street, factory, office edge, death occurred at the time, date and pi		or,
completely filled in by the funerel director,	P	2 Accident 3 Suicide 4 Homicide Could not be determined 28e. Plece of Injury - At hom building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No e, farm, street, factory, office edge, death occurred at the time, date and pi	City or Town, State) lace, and due to the cause(s) and manner es stated.	or,
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettendin completely filled in by the funeral director, page 2 should be deteched for use	edical Certification: To	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowly one) 28e. Plece of Injury - At hom building, etc. (Specify) 28e. Plece of Injury - At hom building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No e, farm, street, factory, office adge, death occurred at the time, date and pl n end/or investigation, in my opinion, death of	City or Town, State) lace, and due to the cause(s) and manner es stated. accurred at the time, date and place, and due to the cause(s)	or,
To the Funeral Director: After this certifica completely filled in by the funerel director, i	edical Certification: To	29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. Name end address of person who completed cause of deeth litem 2	M 1 Yes 2 No e, farm, street, factory, office adge, death occurred at the time, date and pl n end/or investigation, in my opinion, death of	City or Town, State) lace, and due to the cause(s) and manner es stated. accurred at the time, date and place, and due to the cause(s)	d.,
To the Funeral Director: After this certifice completely filled in by the funeral director, it	Medical Certification: To	29a. Certifier (Check only one) 29b. Signature and title of certifier (New York) (New Y	M 1 Yes 2 No e, farm, street, factory, office addge, death occurred at the time, date and plan end/or investigation, in my opinion, death of the control of	City or Town, State) lace, and due to the cause(s) and manner es stated. accurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Pay, Year)	d, DZB

				1 - For Amend Items Registrar	State of M 23a,PtI,2	arylan	d / Depa	rtment of I	Health and	Mental Hy	giene	005-43913	3
	igh.			1. Decedent's Name (First, Middle, I					_	2. Date of Dea	ath Day	3. Time of Death	
		Physici /Medi		Wynald Dean Sm	ith, Sr.					12	. 19	05 2225	М
1	3	Examir		4a. Facility Name (If not institution, g	nive street and number)			4b. City, Town, o	or Location of Dea	ath	4c. Count	ty of Death	
			New York	Upper Chesapea				Bel .				rford	_
	įš,	Funeral		,	. Sex 7. Ag 1120 M 2 ☐ F		ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min	n. (Month, Da	y, Year)	Birthplace (State or Foreig Country)	gn
		Director		237-54-2503 Usual Residence of Decedent		69	113.			May 5,	1936	N. Carolina	_
5)	land m m		10a. State 10b. County		10c. City	, Town or Loc	cation				10d. Inside City Limit	ts
4		Mary	to	Maryland Harfor	d	Fd	gewood					1 ☐ Yes 2 🖸 N	lo
222		urs after death with the Maryland at, or Items 23s or 28s-f show Exercises must be notified at	Funeral Director	10e. Street and Number		1 110	genooa	10f. Zip Code			10g. Citizen of	What Country?	
4		h witi	aiD	455 Meadowood	Drive			210	40			USA	
		death	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13. V	Vas Decedent of I	Hispanic Origin? ((Specify Yes or No- erto Rican, etc.)	- 14. Ra	ce - American Indian, ack, White, etc.	
10	9	or its		1 Never Married 2 Married	1 ☐¥es 2 ☐		ł	☐ Yes 2 No			Speci	fy:	
2	8	72 hours aft "netural", or	d by	3 ☐ Widowed ♣️♠️Divorced	Year or Dates:		10. D				40h Kind al I	White	_
2	5	net adjen	lete	15. Decedent's (Specify only highest	grade completed)		(Give I	ent's Usual Occup kind of work done OO NOT use retire	pation during most of w d)	rorking	160. Kind of t	Business/Industry	
9	12	withir ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		oly Work			Shoe M	lanufacturer	
K	q ₂	Hygi Hygi other		17. Father's Name (First, Middle, La	st)		ASSCIII	OTĂ MOTV		ame (First, Middle,			
10	an	d be ental ked c	To Be	Odell (nmn) S	mith				Dorni	e (nmn)	McMill	an	
	ary	should by and Menta is marked sumatic ev	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street	and Number or I	Pural Route Numbe	er, City or Town	n, State, Zip Code)	
_	ž	2 5 E E		Wynald Dean Smi	th, Jr. /So	on	455 I	Meadowoo	d Drive,		d, Mary	land 21040	
-	J.	of Hea		20a. Method of Disposition 1 → Burial 2 ☐ Cremation 3	□Romoval from State		lace ol Dispos emetery, crem	sition (Name of natory or other pla	ca)	Date		- City or Town, State	
∞	Ē	Pages nent of ant: if it ury or o		4 Donation 5 Other (Spe		Pi	ney Cr	eek Chr.	Cem. 12	2-26-05	Piney	Creek, NC	_
1889	Baltimore	permit. Pag Department Important: i any injury o		21. Signature of Funeral Service Lic	ensee		22 M	Name and Addre	uneral H	Iome, P.A			
$\frac{1}{2}$		20E # 9		Merke Uil	Buch		1	317 Coke	sbury Ro	ad, Abin	gdon, M	aryland 21009	
世				23a. Part I. Enter the disease, or co shock, or heart lailure. List on	emplications that caused by one cause on each li	d the death ine.	n. Do not ente	er the mode of dyi	ng, such as cardi	ac or respiratory ar	rest,	Approximate Interval Between Onset and Death	
	6	Physician	Н	Immediate Cause (Final disease or condition resulting in death)	_a Acul	Te /	Pespi	ratory	Tail	ne		1 days	
	- F	/Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of	10	1		11		
			1	Sequentially list conditions,	b. A CW	a consequ	uence of):	paix	ue_		1.17	otago	
•		ted nslt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Asit		Right	Fail	7	// W	(0	CAL EXAMINER	
4		be executed ician and burial-transit	Xar	that initiated events resulting in death) Last	Due to (or as	a consequ	uence of):	· · · · ·	1 0	71	N WE	DICK!	_
7	260	se be ex ysician e buria	cal		a Chron	re:	ressur	along.	Laily	2 , OX458	Madale Sugar	ndent years	
0	89							1	0	CENTIFICATION	b. \		
त	ŏ	h cert endin use	N/C	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnanc	v	CERTIFIE	23d. D	ate of delivery	
	œ.	deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a			Other (specify)	,	· · · · · · · · · · · · · · · · · · ·	M	onth Day Year	
7	-0	w requires that the death certificat been signed by the attending phy should be detached for use as th	Physician/Medi	9 Unknown						00 0:11			
$\stackrel{\cdot}{\sim}$	Ś	requires that een signed b nould be deta		Part II. Other significant conditions	s contributing to death b	out not resi	ulting in the un	derlying cause gr	ven in Part I.	0 1		ntribute to the cause of death? 3 Probably 4 Unknow	WD
_	ord	sen s	ted	June Cancer	- provat	le ac	WE a	rwhol 1	with dra	wal 1X1	res 2□No	3 Flobably 4 Dollklow	
_	S	ataw asb	Completed by	fall at home	and fracture	die	to hip	on Dece	mberg,			Were autopsy findings availab prior to completion of cause of	le
I		The cate ha	Co	0	V	u	,				2□ No	death? 1 ☐ Yes 2 No	_
-,-	Vital	Physician: The lav this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:			0#	hor	eath (Check only o			_
5	of	Phys this ral dir	.T	Yes 2 Nagner of Death	1 A Inpation		ER/Outpatient 28b. Time of	3LI DOA	4 Nursing	Home 5 Resid			_
5	O	Attending For death. ector: After by the funer.	tion	1 XNatural 5 ☐ Pending	(Month, Da	y Year)	Unknow	28c. Inju Wo	rk?]Yes 2√⊊No	subect			
J	Division	Attendi	fica	3 Suicide 6 Could no	t be 28e. Place of In	jury - At ho	me, larm, stre	et, lactory, office	A	281. Location (S	Street and Num	iber or Rural Route Number,	
	Ö	efter Dire	Certification:	4 Homicide	building, et		<i>(</i>)			City or Tow	vn, State)		
		To the Hospital or Attending Physician: The la within 24 hours effecteath. To the Funeral Director: Affecthis certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best	of my kno	wledge, death	occurred at the ti	me, date and place	ce, and due to the	cause(s) and π	nanner as stated.	
		he Hin 24	edical	one)	and manner st	ated.	tion and/or inv					, and due to the cause(s)	
		To To To Com	Σ	29b. Signature and title of certifier	7 0	^		29c. Licen	se number		29d. Date sign	ed (Month, Day, Year)	_
4				Cherry J	, dem, in	.W_		D.	- 1877	9 1	Jecembe	r 20, 2005	
				30. Name and address of person wh	no completed cause of o	death (Item			C . / .		101	417 210111	
				31. Date liled (Month Day Year)	W, M, D, I	rar's Signa		rd Road	Suite 1	os, rall	500n /	170 21041	_
		St Regist	ate rar	31. Date liled (Month, Day, Year)	6	15	Space.	Le la company de					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 10:45 A M **Physician** February 16, 2005 Rosella Greene /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Prince George Doctor's Community Hospital Lanham If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 📉 F Yrs 05/28/1919 Director South Carolina 248-16-9365 Usual Residence of Decedent with the Maryland 10b. County 10d. Inside City Limits 10c. City. Town or Location 10a. State item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Maryland Prince George Chapel Oaks Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20743 U.S.A. 1314 Nome Street death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ofiled within 72 hours after I Hygiene.

Other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: 1 ☐ Yes XXNo Specify. þ **Black** 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Retail Business Owner Private permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, 9069. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Carrie (Unobtainable) John Goodson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Richard Greene/son 5727 Lincoln Avenue Lanham, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 02/21/2005 | Brentwood, MD 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee 3401 Bladensburg Rd. Brentwood, MD 20722 con 1 23a. Perfl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MINUTES Immediate Cause (Final disease or condition resulting in death) **Physician** DYSRHYTHMIA /Medical Due to (or as a consequence of): **Examiner** MINUTES MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day detached for 4 Pregnant at time of death 5 Other (specify) 9□ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Diabetes page 2 should Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2XNo 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Certification: To 1 X Inpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 🖄 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2/17/2005 D 00 54675 Steolfer 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 818 Goodluck Road Lanham, MD Shobhit Arora, M.D. 31. Date filed (Month, Day, Year) 32 Begistrar's Signature APR 03 2007 Registrar

ORIĞINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Micidle, Last) ÅΜ Physician 12/08/2005 1:18 Arlin Dale Altimus 4c, County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death dene e Prince Georges Cheverly Prince Georges Hospital Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/05/1940 Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** MIXM 2DF Days Hours Pennsylvania Director 186-32-2631 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location toa State t of Health and Meniai Hygiens. If them 27 is merked ather than "natural", or ferms 23s or 28s-f slider or other triumstic invent, the Medical Examine must be modified as 1 Yes 2000 Maryland | Prince Georges Upper Marlboro 10g. Cilizan of What Country? 10f. Zip Code 10e, Street and Number USA 20774 67 Herrington Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② DNo II Yes, Give Year of Dates; 13, Was Dacadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Martel Status Black, White, etc. 1 Never Married 2 Married 1 Yes XX No Specify: ā White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 185. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CVS Pharmacist 18. Mother's Name (First, Middle, Malden Sumama) 17. Father's Name (First, Middle, Last) Elma Frances Mack Wilbur Dale Altimus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) 67 Herrington Drive Upper Marlboro, MD 20774 Kathleen E. Altimus 205. Place of Disposition (Name of cemetery, cramatory or other place) 20c. Location - City or Town, State 20s. Method of Disposition Surjet 200 Cremation 3 Removal from State Department o Important: II any injury or 12/10/2005 Waldorf, MD 4 Donation 5 Other (Specify) Huntt Crematory 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service I 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) in farther Doe to for as a consequence of. aminer: Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initially a vents resulting in death) Last Due to (or as a consequence within 24 hours after detaith. In the Funeral Directur: After tibls certificate has linen signigd by the attending physician and for pletely tilled in by the Junesal director, page 2 sthould be detached for use as the buriet-transit a and Islan/Medica IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fejal death 23d. Date of delivery 29b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Cither (specify) □Ves Z□No Physi 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 Yes 2 No 3 Probably 4 Unknown plent 24b. Were sutopsy findings available prior to completion of cause of death? 24e. Was an Compl Ja soffee sion 2 ANO TOYES ZONO 1 Ves 25. Was case reletted to medical examiner? * 26. Place of Death (Check only one) Hospilal: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 0 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Certification; 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident € [Could not be 3 | | Svicice 281. Location (Street and Number of Rural Route Number, City or Town, State) 28s. Place of miury - Al home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide (A Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. adical 29e. Certifier (Cheek only one) 295. Signature and title of confiner 29d. Date signed (Month, Day, Year) 29c. License number D JUX24 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) Finn. AVE #18 Paper Marshoad 3/2nn 31. Date filed (Month, Day, Year) State OEC 12

Registrar

	State of Maryland / Department of Health a 1- State Registrar Certificate of Death	nd Mental Hygiene Reg. No. 2005 – A	43916
	Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
Physician	Unknown 05-00099	Month Day Year	01 0/ pM
/Medical Examiner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of	January 4, 2005 Death 4c. County of Death	01:24 P
	12105 Old Fort Road, South Fort Washingt		rge's
Funeral Director	5. Social Security Number unk 6. Sex unk 1 M 2 F unk 7. Age (In yrs. last birthday) 4 Months Days Hours 4 Hounder 1 Year 1 Hounder 2 Hounder 1 Year 1 Hounder 2 Hounder 1 Year 1 Hounder 2	Min. 8. Date of Birth UNK 9. Birthpl (Month, Day, Year) 9. Birthpl Count UNK	ace (State or Foreign try)
D	Usual Residence of Decedent		
Maryian -f show flied at	10a. State unk 10b. County unk 10c. City, Town or Location	unk 110	0d, Inside City Limits nk □Yes 2 □ No
with the Mar 8a or 28e-f s 1 be notified	10e. Street and Number unk 10f. Zip Code	unk 10g. Citizen of What Count	try? un
ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Pygiene. If item 27 is marked other than "neturel", or items 23s or 28e-f show or other traumatic event, the Medical Examinar must be notified at To Be Completed by Funeral Director	11. Marital Status unk 12. Was Decedent Ever in Uank Armed Forces? 1 Yes 2 No If Yes, Give 1 Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No No 1 Yes 2 No No No No No No No	in? (Specify Yes or No- Puerto Rican, etc.) 14. Race - America Black, White, e	
ed within 72 houygiene. The than "neture t, the Madcal E	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	of working unk 16b. Kind of Business/Ind	ustry un
ygiene ygiene thertha	unk unk	's Name (First, Middle, Maiden Surname)	amle
d be fill notal H ed out	17. Father's Name (First, Middle, Last) 18. Mother	s Name (First, Middle, Malden Sumame)	unk
12 should be filed within in and Mental Hygiene. 7 is marked other than "reaumatic event, the Market To Be Comple	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	or Rural Route Number, City or Town, State, Zip	Code)
nd 2 alth a 27 is	O.C.M.E. 111 Penn Street Ba	altimore, MD 21201	
pages 1 aent of Heisen 11 if item 17 or other	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 ☒ Other (Specify) in state	Date 20c. Location - City or Tow	wn, State
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra ance.	21. Signature of Funeral Service Light, se Director State Anatomy Bo	oard 655 W. Baltimore S	treet
icate be executed //Medical s the burial-transit sthe burial-transit cdical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, as heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Interval Between Onset and Death
e death certif he attending red for use a	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	23d. Date of deliver	ry Day Year
signed by the detact	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the 1 ☐ Yes 2 ☐ No 3 ☐ Proba	
The law ate has b page 2 sl		autopsy perior to compensation of the compensa	osy findings available apletion of cause of 2 No
	examiner?	of Death (Check only one)	
Physical direction of the control of	1 inpatient 2 Envoutpatient 3 DOA 4 Nut	sing Home 5 Residence 6 Other (Specify, 28d. Describe how injury occurred)
After fune	1 Natural 5 Pending Formal Day Year) Found 3M 1 1 Yes 2 1	Sulvert short	
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After templately filled in by the funeral Medical Certification:	2 Accident 3 Suicide 4 Homicide 1 Homicide 1 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found in wooded area	28f. Location (Street and Number or Rural City or Town, State) Reav of Old FovtRd Fortwas	Route Number, 12105 Liugton Mi
the Hospita thin 24 hours the Funeral mpletely filled	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and an analysis of examination and/or investigation, in my opinion, deat and manner stated.	place, and due to the cause(s) and manner as sta	ated.
To the Hos within 24 h To the Fur completely	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, D	Day, Year)
- s + ō	Derve Helder OCME	Januaryi	4,2005
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Str		
State Registrar	31. Date filed (MSCP Pay2Year) 2007 Apagistrar's Signature		

DHMH 17 Rev 1/2001

Contraction Contraction		1 - State Registrar Ce	rtificate of Death	B	leg. No. 2005 —	43918
## A partity Name of rice contains, pre-steed and number Jacksonville Road @ Alfred Lawson Rd Jacksonville Road @ Sign Sign	nvsician			Month	Day Year	
Jacksonville Road @ Affred Lawson Rd Crisfield Somerset So	Medical		4b. City. Town, or Location of E			0215 P "
214-70-5726 Yes 20 F 45 vs. works Days Rours Min. Occarity By 19659 Contribution Country William Residence of Geodesic Sear Number 100 Color Sear of Number 100 Color Sear	ammer					
100 Sale 100 Courty 100 College 100				Min. Month, Day	9. Birthplac Country	e (State or Foreign ID
23. Part I. Enies the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate cause (final resulting in death) Approximate shock, or heart failure. List only one cause on each line. Approximate cause (final resulting in death) Approximate cause (final resulting in death) Approximate cause (final resulting in death) Approximate cause (final resulting in death) Approximate cause. Enter Underlying resulting in death) Approximate cause. Enter Underlying resulting in death) Approximate cause. Enter Underlying resulting in death) Approximate cause. Enter Underlying resulting in death) Approximate cause. Enter Underlying resulting in death) Approximate cause. Enter Underlying resulting in death) Approximate cause. Enter Underlying resulting in death) Approximate cause. Enter Underlying resulting in death) Approximate cause (final resulting i			ocation		10d.	Inside City Limits
23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Implication	tor	MD Somerset Crist	ield			1 ☐ Yes 2√ No
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, which cause the death of the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cause) Sequentially list conditions, and the line of death of the cause of the line of death of the cause. Enter Underlying or productions, and the line of death of the cause of the line of death of the line of line of line of the line of the line of l	Direc			1	-	?
16a Decidents Education 16a Decidents (Second) 16a Decidents (Sec	erai			? (Specify Yes or No-		Indian.
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final resulting in death)	Fun	1 ▼ Never Married 2 Married 1 Tyes 2 No		Puèrto Rican, etc.)		
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shocks, or heart failure. List only one cause on each line.	d by	3 Widowed 4 Divorced Year or Dates:		1	WILL	
23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart flatine. List only one cause on each line. Approximate shock, or heart flatine. List only one cause on each line. Approximate shock, or heart flatine. List only one cause on each line. Approximate shock, or heart flatine. List only one cause on each line. Approximate shock, or heart flatine. List only one cause on each line. Approximate shock, or heart flatine. List only one cause on each line. Approximate shock or sh	ompiete	(Specify only highest grade completed) (Giv. Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of DO NOT use retired)	f working		ary
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Pinal Part) in the cause of t	3e C	17. Father's Name (First, Middle, Last)	18. Mother's		Maiden Surname)	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown heart failure. List only one cause on each line. Immediate Cause (Final resulting in death) Due to (or as a consequence of): Bequentially list conditions, learner indights cause. Enter Underlying Cause. Enter Underl	P.			-		4.1
23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Underlying cause in the cause of death of the cause						000)
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each file. Immediate Cause (Final resulting in death) 24. Part II. Enter the disease, or complications, shock, or heart failure. List only one cause on each file. 25. Was deaded to death or complications, and the death of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause. Enter Underlying C		20a. Method of Disposition 20b. Place of Disp	osition (Name of			, State
23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory arrest, show, near the mode of dying, such as cardac or respiratory arrest. Immediate Cause (Final Immediate Cause (`4 □Donation 5 □ Other (Specify) All Cour	_	_		MD
23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardac or respiratory arrest, show, near the mode of dying, such as cardac or respiratory arrest. Immediate Cause (Final Immediate Cause (once	21. Signature of Funeral Service Licensee	2. Name and Address of Facility Bradshaw & Sons	Funeral Ho	me	7
Immediate Cause (Final disease or conditions causes (Final Index or the cause of conditions causes or conditions cause. Enter Underlying a sent to for as a consequence of): Sequentially list conditions cause. Enter Underlying cause. Enter Underlying cause. Enter Underlying that initiated events reculting in seath) Last FEEMALE: 23c. If yes, outcome of pregnancy cause. Enter Underlying cause. Enter Underlying cause enter the cause of conditions cause. Enter Underlying cause enter the cause. Enter Underlying cause enter the cause. Enter Underlying cause enter the cause. Enter Underlying cause enter the cause. Enter Underlying cause enter the cause. Enter Underlying cause enter the cause of death?		23a. Part1. Enter the disease, or complications that caused the death. Do not er			est. A	oproximate
Due to (or as a consequence of): Sequentially list conditions of light cause. Enter Underlying to immediate cause. Enter Underlying cause. Enter Underlying cause. Enter Underlying cause. Enter Underlying cause. Enter Underlying cause. Enter Underlying cause. Enter Underlying cause. Enter Underlying cause. Enter Underlying cause (Disease or Injury resulting in dealth) Last IF FEMALE: 23b. Was deedend pregnant in the past 12 months? 1 res 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 res 2 No 3 Probably 4 (Dinknown author) of cause of leath? 1 res 2 No 3 Probably 4 (Dinknown author) of cause of leath? 1 res 2 No 3 Probably 4 (Dinknown author) of cause of leath? 1 res 2 No 3 Probably 4 (Dinknown author) of cause of leath? 1 res 2 No 3 Probably 4 (Dinknown author) of cause of leath? 1 res 2 No 3 Probably 4 (Dinknown author) of cause of leath? 1 res 2 No 3 Probably 4 (Dinknown author) of cause of leath? 1 res 2 No 3 Probably 4 (Dinknown author) of cause of leath? 1 res 2 No 3 Probably 4 (Dinknown author) of cause of leath? 1 res 2 No 1	cian	Immediate Cause (Final disease or condition	nined		Ö	nset and Death
The standard of the standard		resulting in death)				
Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of pregnancy of the consequence of pregnancy of the consequence of the cons	je je	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
IF FEMALE: 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year 1 Ves 2 No 3 Probably 4 Vencount 1 Ves 2 No 3 Probably 4 Vencount 1 Ves 2 No 3 Probably 4 Vencount 1 Ves 2 No 3 Probably 4 Vencount 1 Ves 2 No 3 Probably 4 Vencount 1 Ves 2 No 3 Probably 4 Vencount 1 Ves 2 No 1 Ves 2 No 1 Ves 2 No 1 Ves 2 No Ves Vencount 1 Ves 2 No Ves Vencount 1 Ves	tamir	that initiated events c.				
24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 1 No 25. Was case referred to medical examiner? 1 No 26. Place of Death (Check only one) 27. Manner of Death 1 Natural case of No 28a. Date of Injury 28b. Time of Injury at Work? 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 20d. Was an autopsy findings available prior to completion of cause of death of Case of Death (Check only one) 24b. Were autopsy findings available prior to completion of cause of death of Death 1 Natural 2 No 28b. Place of Death (Check only one) 28d. Describe how injury occurred 28d. Describe how i		Due to (or as a consequence of):				
24a. Was an autopsy findings available prior to completion of cause of death? 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 1 Natural candidate investigation of Could not be determined and Could not be determined by a country of the coulding etc. (Specify) 28b. Time of Injury at Work? 27c. Manner of Death 28c. Injury at Work? 27c. Manner of Death 28d. Describe how injury occurred injury at Work? 28d. Describe how injury occurred at the time, date and place, and due to the cause(s) and manner as stated. 28d. Describe how injury occurred at the time, date and place, and due to the cause(s) and manner as stated. 28d. Describe how injury occurred at the time, date and place, and due to the cause(s) and manner as stated. 28d. Describe how injury at Work? 28d. Describe how injury occurred at the time, date and place, and due to the cause(s) and manner as stated. 28d. De	ledic	d				
24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 1 No 25. Was case referred to medical examiner? 1 No 26. Place of Death (Check only one) 27. Manner of Death 1 Natural case of No 28a. Date of Injury 28b. Time of Injury at Work? 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 20d. Was an autopsy findings available prior to completion of cause of death of Case of Death (Check only one) 24b. Were autopsy findings available prior to completion of cause of death of Death 1 Natural 2 No 28b. Place of Death (Check only one) 28d. Describe how injury occurred 28d. Describe how i	lan/N	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3				v Year
24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 200 1 Yes 2 No 3 Probably 4 200 1 Yes 2 No Yes 1 Yes 2 No Yes 1 Yes 2 Yes	ysic	1 Yes 2 No	_] Other (specify)			
24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 25. Was case referred to medical examiner? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No No Yes 2 No 1	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob		5.4
25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death Dea				_		/\
25. Was case referred to medical examiner? 1	mple			autops	n 24b. Were autopsy prior to compl med? death?	findings available etion of cause of
27. Manner of Death Natural S Pending investigation S Could not be determined	e CO	25. Was case relerred to medical	26. Place of		2 No 1 Yes 2L	No
27. Manner of Death Natural Natu	00	examiner? Hospital:	nt 3 DOA Other: 4 Nursi			At Scene
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 24, 2005		1 Natural 5 Pending (Month, Day Year) Injury	of 28c. Injury at Work?			
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 24, 2005	ficat	Could get be	13	281. Location (St	treet and Number or Rural R	oute Number,
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 24, 2005	Certi					id MD
Paped Synthall Mas OCME February 24, 2005	ical	(Check only 2 Medical Examiner: On the basis of examination and/or in		place, and due to the ca	ause(s) and manner as state	
Paped Synthall Mas OCME February 24, 2005	Med	74-	29c. License number	2:	9d. Date signed (Month, Day	v, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		Donat Guiller 11 Mil	OCME	F	Tebruary 24, 2	2005
PAMELA SOUTHALL M.D. 111 Penn Street Baltimore, Maryland 21201		* When I will a series				

12-05969 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Abdul Jaafar Aziz 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 0000 hrs Medical Examiner February 21, 2005 Abdul Jaafar Aziz 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Circuit Court for Baltimore City Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** oreign Days Months Hours Director Country) Maryland 215-35-7704 1 X M 2 18 Jan. 12. 1987 Yrs Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Ę 1 XYes 2 No other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once. N/ABaltimore Maryland ore, MD 21215-0036 ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Director 10g, Citizen of What Country 10f, Zip Code 10e. Street and Number 21229 4634 Parkton Street United States Funeral 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican. etc.) 1 X Never Married 2 Armed Forces' White, etc. Married 2X No Yes If item 27 is marked other than "natural", or Yes, Give Yea Widowed Divorced Yes 2 X No specify: Specify: Black 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8 N/A N/A 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) event, 1 Be Martina Taylor Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Sirichte's Attorney 1 Gregg L. Bernstein/Baltimre ဥ Gregg L. North Calvert Street, Baltimore, MD 21202 20c. Location - City or Town, State N/A 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date Baltimore, crematory or other place) N/A permit. Pages 1 Department of H N/A Donation 5 X Other Specify: Periodic S Tours 21. Signature of Funeral Service Licensee N/A 22. Name and Address of Facility N/A 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a Blunt Force Injuries complicated by Drowning Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical UNPENDED AMENDED attending physician or use as the burial certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of Other (Specify) õ Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Yes 2 ✔ No 3 Probably 4 Completed After this certificate has been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2 V No Yes 2 No 26.Place of Death (Check only one) e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certifi 25. Was case referred to medical Be examiner? Hospital: Other4 Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 V Yes 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work 28d. Describe how injury occurred Certification: Feb 21, 2005 Subject assaulted 1445 hrs Natura Yes 2 V No I Director: ed in by the f Pending Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number City Suicide Could not be or Town, State)

Baltimore Harbor/3301 Waterview Avenue, Baltimore Cit determined (Specify) Harbor 4 V Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Fo the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registral

OCME 2006

State

Jack Titus MD

31. Date filed (M

who completed cause of death (Item 23a)

Registrar's Signa

Deputy Chief Medical Examiner

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

August 30, 2012

		I	Please Amend 21 per FD G94	Type or Print in 2,8/13/13 TR	Black I	ndelible Ir	k. Ensure	All Copie	s Are	Legible	•			
		-	For State Registrar	State of iviaryia	Mentai m	Reg. No. 2005 4392.0								
	Dhusiaia	. ,	Decedent's Name (First, Middle, Last)		rtificate of		2. Date of D	eath	3. Time of Death				
	Physicia Medic	al	Jay Wilson Tarmo			· · · · · · · · · · · · · · · · · · ·		Octobe		2005	1901 M			
	Examin	er	4a. Facility Name (if not institution, give s The Memorial Hosp			4b. City, Town,	or Location of Dea	ath	4c. County of Death Talbot					
~~ >	Funeral		5. Social Security Number 6. Se		s. last birthday)		If Under 24 Hi		rth	thplace (State or Foreign				
	Director		-13 20 110	Хм 2 □ ғ 77	Yrs.	Months	Hours Mil	March			cyland			
	and show	ō	Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	ocation		prarch_	7, 17	20 1141	10d. Inside City Limits			
	Maryle 286-1	Director	Maryland Talbot	Ea	ston						1 ☐ Yes 2 🔀 No			
	P or S		10e. Street and Number			10f. Zip Code				zen of What Co	ountry?			
	ath wit	Funerai	29817 Grasswell D	12. Was Decedent Ever in t	118 113	21601 Was Decedent of	Hispanic Origin?	Specify Yes or No		ISA 14. Race - Ame	wisen Indian			
ထ	ar dae or Ite	by Fi	11. Mantai Status 1 ☐ Never Married 2 💢 Married	Armed Forces?		If Yes, specify Cub	oan, Mexican, Pue	rto Rican, etc.)		Black, Whit	e, etc.			
800	urs aft ure!",	ted t	3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2 🔯 N	o Specify:			Specify: W.I	nite			
15-(72 hou	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occu kind of work done OO NOT use retired	during most of w	orking	16b. Kii	/industry				
212	within plane.		Elementary/Secondary (0-12)	tter	Waterfowl									
pu	flad d oth d oth		17. Father's Name (First, Middle, Last)				ame (First, Middle		·					
yla	Ment Market	잍	Joseph Daniel Tar			1	a Liebow							
Baltimore, Maryland 21215-0036	2 sho th and 27 is r traun		19a. Informant's Name/Relationship (Type Barbara E. Tarmon			ing Address (Stree 7 Grassw			-		o Code)			
ē,	f Haali f Haali tem 2		20a. Method of Disposition	20b	. Place of Dispo	osition (Name of	. 1	Date		cation - City or	Town, State			
E	Page nent o ant: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			matory or other pla Memorial		/24/2005	East	ton. Ma	rvland			
3alti	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygians. Importment of Health and Mental Hygians. surprises the X1 is marked other then "neturel", or items 23s or 28s-1 show any injury or other traumetic event, the Madical Examinar must be notified at once.		21 Signature of Funeral Service Lineneae 22 Name and Address of Facility											
ш	<u>0</u> 0 = 0 0		John R. Merceron per DVR Fellows, Helfenbein & Newnam Funeral Home, PA 200 S. Harrison St, Easton, MD 21601											
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of):											
	hysician⊬ ∡Medical													
-	Éxaminer	L	Sequentially list conditions,				Years							
	9 PE -	Examiner	if any, leading to immediate cause Enter Unerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):											
		Exar												
		Ical	L	d										
Box 68760	Tificat Ing ph e as th	Physician/Medica	IF FEMALE:							-	=======================================			
ox e	ath ce attend for us	clan/	in the past 12 months?	23c. If yes, outcome of preg 1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time of	etal death 3	Ectopic pregnar Other (specify)	ю		2	23d. Date of delivery Month Day Yea				
ă	y the gached	hysi	1 Yes 2 No 9 Unknown	9 Unknown										
P.0	that the property of details		Part II. Other significant conditions con		23e. Did tobacco use contribute to the cause of death?									
ds,	iquirae	pet	Congestive Heart	1 🙆	Yes 2	robably 4 🗆 Unknown								
000	law re has be is 2 sh	Completed by									topsy findings available completion of cause of			
بر سے	n: Ine ficata or, pag		25. Was case referred to medical			26.5	Place of Death (Ch		ormed? 2 A No		2 □ No			
Vita :	s cart	To Be	evaminer?	lospital:	Int	26. Place of Death (Check only one) 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)								
Division of Vital Records, P.O.	tar thi		27. Manner of Death 1 ☐ XNatural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	f 28c. Inju		I. Describe how injury occurred							
<u>io</u>	to the nospitel or Attending Prysicien: The law raquites that the destin certificate bath within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physici complately filled in by the funeral director, page 2 should be detached for use as the buth the funeral director is a should be detached for use as the buth the funeral director is a should be detached for use as the buth the funeral director is a should be detached for use as the buth the funeral director is a should be detached for use as the buth the funeral director is a should be detached for use as the buth the funeral director is a should be detached for use as the buth the funeral director is a should be detached for use as the buth the funeral director is a should be detached for use as the buth the funeral director is a should be detached for use as the buth the funeral director is a should be detached for use as the buth the funeral director is a should be detached for use as the buth the funeral director is a should be detached for use as the buth the funeral director is a should be detached for use as the buth the funeral director is a should be detached for use as the buth the funeral director is a should be detached for use as the buth the funeral director is a should be detached for use as the buth the funeral director is a should be detached for use and the funeral director is a should be detached for use and the funeral director is a should be detached for use and the funeral director is a should be detached for use and the funeral director is a should be detached for use and the funeral director is a should be detached for the funeral director is a should be detached for the funeral director is a should be detached for the funeral director is a should be detached for the funeral director is a should be detached for the funeral director is a should be detached for the funeral director is a should be detached for the funeral director is a should be detached for the funeral director is a sh	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be			injury work? M 1 ☐ Yes 2 ☐ No								
ivis	aftar of Art Direct Jin by	Cert	4 Hornicide determined	eet, factory, office		28f. Location (City or Tov	(Street and Number or Rural Route Number, wn, State)							
	sepite hours inerel ly filled	edical	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	the Ho the Fu the Fu	ΣI	(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	5 to 6		29b. Signature and title of cortifier	29c, Licens			signed (Month	, Day, Year)						
			30. Name and address of person who or	1 address of person who completed cause of death (Item 23a) (Type, Print)										
		David G. Oliver, M.D. 503 Cynwood Drive Easton, MD 21601												
		State istrar 31. Date filed (Month, Day, Year) 32 Registrar's Signature 4 AUG 1 3 2013						1						

			Ame	Pleas end #21	se Type or per FD s State 8	Pr !!	nt in E 9/1(aryland	Slack ir 0/13 T 1/Depa	ndelib RT artmer	le In⊩ nt of ⊢	c. Ens lealth	ure A and N	\II Copie /Iental Hy	es Ar vaien	e Legib e	le.		
			State Registrar	rtificate of Death Reg. No. 200							5 4392	_						
	Physicia Medic	al	William Nelson Robinson May									2. Date of Do Month May) ^{2y} 2°C	3. Time of Deat 2:30 P			
	Examir	er										c. County of D						
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt					st birthday)		r 1 Year Days		24 Hrs. Min.	8. Date of Bi	rth	9.	Birthplace (State or Fore	eign	
	Director		220-38-53 Usual Residence of	1 XM 2 □ F	162 yrs 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1							1942 Maryland						
Baltimore, Maryland 21215-0036	permit. Fage 1 and 2 should be filed within 72 hours effer death with the Meryland Depertment of Health and Mental Hyglene. Inpoprtant: If them 27 is merked other then "neturali", or items 29e or 28e-f show eny injury or other treumetic event, the Medical Examiner must be natified at once.	io	10a. State		10c. City, Town or Location					ation					10d. Inside City Limits			
		Director	MD 10e. Street and Num	MD Worcester Oc. 10e. Street and Number					cean Pines 10f. Zip Code 10g. Citizen of							1 🗆 Yes 2 🛣	No	
		Funeral	6 Seagrave Lane						21811 USA							Country :		
	r death or item direc m	y Fur	11. Marital Status 1 ☐ Never Marri		I2. Was Decedent Ever in U.S. 13. V Armed Forces? If 1 ☐ Yes 2 【XNo			Nas Decedent of Hispanic Origin? (Spec f Yes, specify Cuban, Mexican, Puerto R				cify Yes or No- Rican, etc.)	-	14. Race - American Indian, Black, White, etc.				
	urai", o LEcon	ted by	3 Widowed 4	2 LALI ve ates.	No	1	☐ Yes	Yes 2 XNo Specify:				Specify: White						
	72 hou n "netu Andles	Completed	(Specify only highest grade completed) (Give ki							lent's Usual Occupation ind of work done during most of working O NOT use retired)						o. Kind of Business/Industry		
	of filed within that Hyglene.		Elementary/Secondary (0-12) College (1-12)				4 Of 5+)			h Analyst				US	Government			
		To Be	17. Father's Name (First, Middle, Last)							18. Mother's Name (First, Middle, Maiden Surname)								
	nould bund Me s merk umetic		Calvin Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Maili						g Address	(Street a	Ida Talbott It and Number or Rural Route Number, City or Town, State, Zip Code)							
	end 2 st Heelth a tem 27 ls		Frieda Robinson 6 Seagrave Lane, Oc															
	mit. Pege 1 er bertment of H. bortant: if iter injury or ott		20a. Method of Disposition 1 Burial 2 🖾 Cremation 3 🗆 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)							ther place	· .	Date 20c. Location - City or Town, State						
altin			4 Donation 5 Other (Specify) CApe Henlopen Crem. 5/6/2005 Frankford, DE 21. Signature of Funeral Service Licensee 22, Name, and Address of Facility															
Ď	Depermit Depermit Impon eny ir	ń.	21. Signature of Funeral Service Licensee William Kirk Burbage per DVR 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811															
-2			23a. Part 1. Enter the shock, or heart Immediate Cause (F	Do not ente	er the mode of dying, such as cardiac or respiratory arrest,							Approximate Interval Between Onset and Death						
Priysician/ -Medical			disease or condition resulting in death) Amyloidosis Due to (or as a consequence of):											+	_			
	siclen end puriel-transit	al Examiner	Sequentially list conditions, b. — Due to (or as a consequence of):										-					
			cause. Enter Underlying Gause (Disease or injury															
			that initiated events resulting in death) Last Due to (or as a consequence of):															
1260	icete b g physik ss the b	ledic	d															
P.O. Box 68760	h certif tending or use e	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal death 3												23d. Date of			
8	ined by the ett	yslc	1 Yes 2 No 9 Unknown 5 Other (specification of the specification							ecify)	Y)					Month Day Year		
O		DY P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death?							
rds,	equires een sig hould b	eted													Probably 4 💢 Unkno			
eco	e has bage 2 s	Completed											24a. Was autoperfo	DSV	prior t		le if	
<u>a</u>	ien: In rtificat ctor, pa		25. Was case referred to medical 26. Place of Dec examiner?								ce of Deat	h <i>(Check</i>		2.X. N	0 1 1	′es 2 □ No		
Division of Vital Records,	or Attending Private after death. Director: After this c	욛	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ I								4 🗆 NU		sing Home 5 👿 Residence 6 🗆 Other (Specify)					
		Certificate:	1 Natural 2 Accident	5 Pending Investigat	(Mon	28a. Date of injury 28b. Time of 28c. Injury at york? (Month, Day, Year) injury M 1 □ Ves 2 □ No					28d. Describe how injury occurred							
visic		Ĕ	3 Suicide 4 Homicide		ace of Injury - At home, farm, street, fac illding, etc. (Specify)			et, factory				28f. Location (Street and Number or Run City or Town, State)			Rural Route Number,			
<u>ā</u>												stated.	-					
	the Ho nin 24 h the Fui npletely	Medical	(Check 2 U Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											ated.				
	Met vol	29b. Signature and title of certifier 29c. License number 29d. Date 5/6/2								ate signed (Month, Day, Year)								
		1	30. Name and addres					3a) (Type, Pr										
			Joseph Mo						Ber	lin,	MD 2	1811					_	
	Stat Registra	6			2013	gistrar'	's Signatur	1 6	ale									